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ORIGINAL ARTICLES.

ICE IN THE TREATMENT OF ACUTE PNEUMONIA.

A Collective Report.

BY THOMAS J. MAYS, M.D.,

PROFESSOR OF DISEASES OF THE CHEST IN THE PHILADELPHIA POLYCLINIC, VISITING PHYSICIAN TO THE RUSH HOSPITAL FOR CONSUMPTIVES, ETC.

WHATEVER its nature may be, it is quite certain that no other disease has elicited a greater number of conflicting opinions concerning its treatment than has croupous pneumonia. Forty years ago bleeding and blistering were regarded as its specifics; but these are now, and for the last twenty years have been, scarcely thought of in this connection. In the meantime hot poultices, aconite, veratrum viride, digitalis, quinine, etc., took their places; yet it is not too much to say that these have all led to disappointment and have come to grief in the retort of clinical experience, and that finally the profession has gravitated to the conviction that the disease is self-limited in duration, and that hence all efforts to control its course are fruitless, if not actually harmful.

To be thus compelled to stand before a disease and acknowledge our helplessness and impotency is, to say the least, an unenviable position, but I must confess that until I became familiar with the value of local cold applications in pneumonia I was in entire accord with this idea. Since then I may say that I am able to approach a case of pneumonia with a greater degree of assurance—not with the feeling, however, that we possess a specific, but with the confidence that we have in cold an agency with which we are able to impress and circumvent the severity of the pneumonic process. I believe that cold properly applied will affect the death-rate of pneumonia as profoundly as it has affected that of typhoid fever, and, although I do not expect a rapid introduction of this measure, on account of a deep-rooted prejudice which exists against the use of cold in almost all internal diseases, I trust that the evidence which is herewith submitted will serve to commend it to the serious attention of the profession.

Under the titles "Can Croupous Pneumonia be Aborted?" and "Ice in the Treatment of Croupous Pneumonia," I contributed two papers to THE MEDICAL NEWS of September 24, 1892, and January 21, 1893, respectively, in which are related three cases of pneumonia that were treated principally with applications of ice to the chest. After the appearance of the first paper I instituted a collective investigation on a small scale by sending a number of circulars[1] to various members of the profession, inviting a trial of the ice-treatment, and as a result of this inquiry I submit the following abstracts of cases which have been kindly returned to me, and also of those of other cases which I have collected from the literature on the subject.

CASE I.[2]—M., aged thirty-six years, was attacked with right basic pneumonia March 10, 1892, when the temperature reached 105°, pulse 112, and respiration 26. Ice was applied over the affected area until the 16th inst., when crisis followed the hypodermatic injection of ¼ of a grain of pilocarpine, and the temperature fell to normal. Recovery was retarded by fibrinous pleurisy. The patient was able to sit up on April 11th.

CASE II.— F., aged seventy-four years, had pneumonia of the right base, associated with delirium. Ice was applied over the affected area from the 6th to the 10th of March, 1892, when the crisis occurred and the ice-treatment was discontinued. The temperature and pulse records are lost, but the improvement was prompt and rapid.

CASE III.—M., four years of age, was first seen March 6, 1892, when the child was intensely delirious and quite insensible. Pneumonia of the right base existed. Ice was applied from March 7th to the 13th, when lysis took place. There was no pulse or temperature record kept, but it was "a very severe case, in which the cold acted like a charm."

CASE IV.—M., fourteen years old, had pneumonia of both bases, the consolidation extending above the nipple on the right side. Ice was applied around the whole chest from the 22d to the 29th of March, 1892. At the beginning of the application the temperature was 105°, pulse 100, and respiration 28. Crisis occurred on the 28th, when the temperature became normal.

CASE V.—M. aged two years, had pneumonia, most severely at the left base, and was very delirious. Ice was applied March 12th, when the temperature was 101°, pulse 150, respiration 40. The ice-applications were continued until the 14th, when crisis took place, and temperature became normal. "I think this can be taken as an aborted case."

CASE VI.—F., aged twenty-three, had a chill January 7, 1892, which was followed by pneumonia

[1] Similar circulars will be cheerfully sent by the author to any one who may apply for them.

[2] The first eleven cases are reported by Dr. W. Fred. Jackson, of Brockville, Ontario.

implicating the whole of the right lung. On January 8th, when the temperature was 105.2°, the ice was applied, and by next morning the temperature had fallen to 99°, and the next day it was normal. In order to satisfy the patient the ice was continued until the 11th. He also has an organic heart-lesion, which aggravated his condition very much.

CASE VII.—M., aged thirty-four, had pneumonia of the right base. When first seen, January 12th, he was insensible, the temperature was 103°, and he had rusty and bloody expectoration. The ice was applied on this day, and the next morning the temperature had fallen to 100°, but owing to some objection it was taken off, and by evening the temperature had risen to 103.2°. The ice was promptly reapplied, and the following day the temperature reached 100°; a day later crisis occurred and the temperature fell to normal.

CASE VIII.—F., aged sixty-five, had pneumonia of the whole of the right lung. Ice was applied to this side March 16th, when the temperature was 103°; next morning it had fallen to 101°. Owing to prejudice, the applications were discontinued until the morning of the 22d, when she was no better, and the temperature had again risen to 103°. The ice was then reapplied. On the evening of this day the temperature was 101°; the morning and evening of the 23d it was 100° and 99.6°, and crisis occurred on the 24th, when the temperature became normal.

CASE IX.—M , aged forty, had pneumonia of the upper half of the left side and right base. The sputum was bloody. On the morning of February 5, 1892, the date of his initial chill, the ice was applied; his temperature was 104.4°, and in the evening 102°. On the 6th, the morning record was 100°, the evening 99°. On the 7th, crisis supervened and the temperature became normal. The pain which this person experienced was also quickly relieved by the ice. The disease was "aborted in the congestive stage."

CASE X —F., aged thirty-five, had pleuro-pneumonia of the left base. The initial chill was on February 5th, and ice was applied over the left lung on the morning of the 6th, when the temperature was 101°. On the evening of the same day, it was 100°; on the 7th, morning 99.4°, evening 99°. On the 8th, crisis took place, and the temperature was 98°.

CASE XI.—M., aged thirteen, had pneumonia of both bases. Ice was applied around the chest on March 10, 1892, when the temperature was 105°; on the 11th, the record was 103°, and on the 12th, 102°. On the 13th crisis occurred, with a thermometric record of 98°. "A very severe case in which the effect of the cold was very marked." (All of Dr. Jackson's cases received liq. ammon. acetat. ʒij. and spt. ether. nit. ʒj. every hour, well diluted.)

CASE XII. (Reported by Dr. E. W. Blackburn, Stahlstown, Pa.)—The patient was a male, a periodical drinker, aged forty-one, and had pneumonia over the whole of the right lung. The initial chill was on November 10, 1892, following a three days' alcoholic debauch, and the man was first seen on the following day, when his temperature was 103.2°. The ice was then applied. On the 12th, the temperature was 101°; on the 13th, 99°; on the 14th, lysis occurred, with a normal temperature. This patient also received $\frac{1}{10}$ grain of strychnine every four hours.

CASE XIII.—(The following four cases are reported by Dr. J. C. Knipe, Jewish Hospital, Philadelphia.) The patient, a male, aged thirty-seven, an alcoholic, was taken with a chill, which was followed by pneumonia of the left base, on March 11, 1893, two days before admission to the hospital. He was suffering from diarrhea, lead-poisoning, and while in the hospital had an attack of delirium tremens. His temperature ranged from 102° to 103°; the ice was applied for three days, and death took place on the fifth day in the hospital.

CASE XIV.—A male, aged twenty-eight, with pneumonia of the left lung, was admitted October 17th, although he had a chill two days previously. He was delirious, and had rusty and bloody expectoration. The ice was applied over the affected area for five days. His temperature on admission was 104°, afterward from 100° to 102°. He died October 22d. Before this attack he had been suffering from chronic pneumonia of both bases.

CASE XV.—A male, aged seventeen, had pneumonia of the right base, December 27, 1892. On admission, when the ice was applied, his temperature was 103°, and for the next twelve days, during which the ice was continued, it ranged from 101° to 98°, and disease terminated by lysis at the end of that time.

CASE XVI.—A male, aged twenty-one, was seized with pneumonia of the right base February 2, 1893. The ice was applied for six days over the affected area. The temperature remained at 104° and 105.6° until midnight of the second day of the disease, when it dropped to 99.4°. Shortly after this time the patient had another chill, and on the third day, in the morning, the temperature rose to 105°, and in the evening, after a profuse sweat, it fell to 98°; from this time it fluctuated between 104° and 98°, until the seventh day, when it became normal, and remained so. This patient also received aconite, morphine, and ammonium carbonate.

CASE XVII.—(The next two cases are reported by Dr. John A. Fell, of Doylestown, Pa.)—M., aged sixty, had the initial chill, December 20, 1892, and from this time to the afternoon of the 28th, the temperature varied from 102° to 103.5°. On the last date the ice was applied over the lower half of the right lung, the seat of the pneumonia, and at noon of January 1st the temperature was normal, when it was removed. He also received $\frac{1}{20}$ grain of strychnine every four hours until January 1st. This patient also had an old-standing aortic regurgitation. At first he objected to the use of the ice, but it gave him such marked relief from his distressed breathing that he became much pleased with it. He also received two ounces of fresh beef-juice and a glass of milk alternately every two hours.

CASE XVIII.—F., aged seventeen, had pneumonia of the left lung. For the first three days the tinctures of aconite, belladonna, and veratrum viride were used in large doses, and mustard was applied to the affected side, without any apparent effect. Her

temperature was about 103°, and pulse 120. On the fourth day the ice-bags were applied, and in less than twenty-four hours the temperature had fallen to 99°, and the patient experienced a sense of comfort which she had not felt before. Strychnine, quinine, and morphine, were also used. "Her recovery was rapid and complete after using the ice."

CASE XIX. (Reported by Dr. A. Cooper, Brookline, Mass.)—A male, aged thirty-one, had the initial chill on the evening of January 31, 1893, and the expectoration was of a bloody and mucous character from this date. Both bases were involved. On the evening of February 1st the temperature was 102.5°; the next morning it was 104.25°, when the ice was applied. On the evening of this day it was 103°. On the third day it fell to 101°, and was almost normal on the fifth day. The ice was applied for seventy-two hours to the right, and for eighty-six hours to the left side, and the disease subsided by lysis. Dr. Cooper adds: "In six hours after the ice had been applied the temperature dropped from 104.25° to 101°. The ice had been on a very short time when pain and dyspnea ceased. My patient was better on the fifth day than was any case I have had under poultice or hot local treatment on the ninth or twelfth day."

CASE XX. (Reported by Dr. G. H. Franklin, Hightstown, N. J.)—F., five years of age, had an initial chill February 17, 1893, followed by pneumonia of the entire right lung. From this date to the 20th the temperature rose from 102.5° to 104°, and she received the usual treatment for this disease. On the latter day ice was applied to the front and side of right lung, and was continued for seven days, during which time the temperature gradually returned to nearly a normal point (99°). Previously to the ice-treatment large doses of quinine had exerted no influence on the fever. The patient also received $\frac{1}{120}$ grain of strychnine every four hours. This was a case of broncho-pneumonia following measles.

CASE XXI. (Reported by Dr. Eugene P. Bernardy, Philadelphia.)—M., aged twenty-five, was first seen September 15th, although the chill had occurred three days previously. The lower two-thirds of the right lung were involved. Expectoration was copious, rusty, and bloody. The patient was violently delirious; his temperature ranged from 102° to 104°. Ice was applied on the 16th, and was continued to the 19th On the evening of the last date active delirium set in, and the ice was discontinued. After the delirium was under control ice was again applied for three days longer, when the disease terminated by crisis. The patient also received $\frac{1}{100}$ gr. of strychnine every two hours.

CASE XXII. (Reported by Dr. Charles E. Woodward, West Chester, Pa.)—F., aged thirteen, with double pneumonia, had the initial chill March 20, 1893, accompanied by a temperature of 104°. The expectoration was bloody at first, afterward rusty. Crisis took place on the seventh day. Turpentine stupes were applied externally, and strychnine in $\frac{1}{100}$ grain doses was given internally every four hours from the beginning. General sponging with cold water (65°) was used throughout, and ice was applied only three times, and fifteen minutes each time. The superiority of the ice-bag over the cold sponging, was shown by the temperature-record. While the cold sponging reduced the temperature, which was about 104° for seven days, the reduction caused by it was not so pronounced as that which was caused even by the fleeting local application of ice. It is stated that the patient experienced great comfort from the use of the ice-bag.

CASE XXIII. (Reported by Dr. E. R. Snyder, Philadelphia.)—F., aged three years, had double pneumonia, the lower third of the left lung being involved at the beginning, and on the fifth day the lower part of the right lung became implicated. On the sixth day the temperature had risen to 105.4, and the child became unconscious. The whole chest was now enveloped in ice, and in six hours, when the temperature had fallen to 102.5°, the ice was removed. In the next six hours the temperature rose to 104°, when the ice was reapplied, and in one hour the thermometer registered 102.5°. After this the temperature gradually dropped to the normal point. There was good reason for believing that the ice saved the child's life. Strychnine was given hypodermatically in $\frac{1}{60}$ grain doses, and croton oil was applied externally.

CASE XXIV. (Reported by Dr. Walter Webb, Sharon Hill, Pa.)—A male, aged sixteen, had pneumonia of the entire left lung and lower portion of the right. The patient was seen first November 2, 1892, when the temperature was 105°, respiration about 60, and pulse 120. The parents objected to the ice when Dr. Webb first suggested it, but as no improvement in the boy's condition was observed, the parents permitted its use on November 6th, when the evening temperature was 105.2°, and the respiration 64. After this the fever gradually fell until the 14th, when it registered 102° in the evening. The ice was now withdrawn and the temperature rose a degree or more, and the boy complained of severe pain and greater difficulty in breathing. The ice was reapplied on the 17th, the temperature fell, and the patient expressed himself as being greatly relieved when the ice was reapplied. It was continued for two weeks, when the fever had disappeared.

The following six cases are my own:

CASE XXV.—F., twenty-five years of age, with double basic pneumonia, and with pleurisy on the left side, was first seen in the Polyclinic Hospital, November 24, 1891. She had a temperature of 103.4°, and ice-bags were applied over the affected area. The temperature began to decline immediately, and, excepting a slight rise on December 3d, sank to nearly a normal level on the eleventh day.

CASE XXVI.—F., thirty-seven years old, was seen first in the Polyclinic Hospital, June 25, 1892, when she was suffering from pneumonia of the lower half of the right lung, and had a temperature of 103°. Ice was applied at once over the affected area, and by the following morning the temperature had descended to 98.8°, although in the afternoon it rose again to 101.5°. On the

morning of the third day the thermometer registered 98.2°, and in the evening 100.8°. After this, with a few variations, the temperature became normal, and remained so.

CASE XXVII.—M., fifteen years of age, had been having pneumonia of the lower two-thirds of his right lung for about six days before I saw him. On the evening of the second day his temperature was 104.8°, and cold-sponging was resorted to until the sixth day, when the temperature was reduced to 102.8° at 2.30 P.M. Ice-bags were now put over his right chest, and at 1 P.M. of the next day the temperature registered 98.2°, and at 8 P.M. 100°. On the following morning it was reduced to 97°, when the ice-bags were removed until reaction was assured. From this time on, the temperature, with a few exceptions, remained near the normal line, and the boy made a complete recovery.

CASE XXVIII.—A female, eighteen years of age, was first seen by me June 17, 1892, suffering with pneumonia of the whole of the right lung, and having a temperature of 102.8°. The whole right chest was surrounded with ice-bags on the third day of her disease, and by the next morning the temperature had fallen three degrees (to 99.6°), and thereafter became gradually normal. Complete restoration followed at once.

CASE XXIX.—A male, aged forty-five, an inveterate drinker for twenty years, was admitted into the Polyclinic Hospital, December 15, 1892, on the fifth day of a pneumonia involving the whole of the left lung, and with a temperature of 102.6°. The whole left chest was enveloped in ice, and on the morning of the eighth day the temperature was normal. With the exception of a severe attack of delirium, which occurred on the ninth day, the man made an uninterrupted recovery.

CASE XXX.—M., aged thirty-four, had pneumonia of the whole left lung when first seen in the Polyclinic Hospital, March 26, 1893. His evening temperature was 103.8; ice was applied, and the the next morning the pyrexia had fallen to 100.4°. It remained near 101° until the 28th, when it rose to 102.4°. It was now found that the whole lower half of the opposite lung was involved. The man had several attacks of hemoptysis, his face was intensely flushed, and his breathing extremely difficult. Inhalation of oxygen relieved the distress somewhat. The patient was delirious, and had a tendency to coma. The ice was continued on both sides, and the temperature, except on several occasions, was kept between 101° and 102°. Resolution soon followed in both lungs. Owing to the gravity of the condition convalescence was slow, but the man made a good recovery. The ice was continued for twenty days. In addition to the oxygen-inhalations, the patient received strychnine in large doses, by the mouth and hypodermatically, and was liberally fed and stimulated.

The next eighteen cases are reported by Dr. D. B. Lees in an article published in *The Lancet*, November 2, 1889:

CASE XXXI.—M., twenty-five years of age, had pleuro-pneumonia of the right base. On November 15, 1887, the fifth day of the disease, the temperature was 104.8°. The affected side was tightly strapped and an ice-bag applied over the strapping. The temperature fell immediately, and was normal the next morning, when the ice-bag was removed.

CASE XXXII.—M., aged twenty-six, with pneumonia of the left posterior base, was seen on the seventh day, when the temperature was about 104° and ice was applied. During the following night the temperature fell to 99°.

CASE XXXIII.—M., sixteen years old, with pneumonia of the right base, was seen on the fourth day, when his temperature was 104°. Snow was at once applied, and the temperarure fell immediately.

CASE XXXIV.—A child, three years old, had broncho-pneumonia of the base of the lung. The temperature was 104°, and the breathing was very rapid. The ice-bag was applied over the affected lung. Within twenty minutes of its application a distinct change for the better was observed. The breathing became much quicker, the temperature fell at once, and in a few days the patient was quite well.

CASE XXXV.—M., four years of age, had pneumonia of the left posterior base. The temperature was 104.5°, the pulse 140, the respiration 50. Ice-bags were applied over the implicated lung-area, and immediate recovery followed.

CASE XXXVI.—F., four years old, suffered with pneumonia of the lower part of the right lung. When first seen the temperature was 104°, and within a few hours after the ice was applied it fell to 98°. However, it rose again to 101°, and continued at this point for about thirty-six hours, when it fell to 96.5°, and remained subnormal.

CASE XXXVII.—F., thirty-eight years of age, had pneumonia over the left axillary base. The woman was seen first on the fourth day of her illness, when her temperature was 103°. The ice-bag was applied, and by midnight her fever had fallen to 99.6°, and the ice-bag was removed. The temperature rose at once, and the next morning it was 101.5°, and in the evening 104°. No ice was again applied, but the temperature gradually fell, so that on the evening of the next day it reached 99.2°.

CASE XXXVIII.—M., nine years of age, had pleuro-pneumonia of the left base, and a temperature of 103°; ice was applied, and in thirty-six hours it had dropped to 99.4°, and the ice was removed. In eight hours it had risen again to 104°. Reapplication of the ice caused the temperature to sink to 98.4° in sixteen hours, after which it did not again rise above 100°.

CASE XXXIX.—M., twenty-six years old, had pneumonia of the left base. The man was seen on the third day, when his temperature was 103°. An ice-bag was applied, and the temperature fell promptly to 97.6°. On the morning of the fourth day the ice was removed, and the temperature rose directly. When it reached 100° the ice-bag was replaced. The rise, however, continued up to 102°, from which point the temperature fell again to the normal on the fifth day.

CASE XL.—F., six and a half months old, had broncho-pneumonia of the root of the right lung, with a temperature of 105°. Twenty-four hours after the

application of the ice-bag the pyrexia fell to 101.4° The ice was then removed, and the temperature rose to 103°, but fell again to 100.4°. A sudden rise to 105.6° was caused by an implication of the root of the opposite lung. The ice-bag being applied to the new focus of inflammation, the fever fell to 98.8° in nine hours, and after a few small transitory rises, recovery slowly occurred.

CASE XLI.—F., fifteen years old, had an attack of broncho-pneumonia, with general bronchitis. There was dulness over the whole front of the left lung, with a temperature of 104.2°, on January 24, 1885, when the girl was first seen. Poultices were applied, and the next day she was worse, the temperature having risen to 105°. Venesection—ten ounces—gave great and immediate relief. The temperature fell 1°, and on the evening of the next day (the third in the hospital) the child was worse than ever, her temperature reaching 105.6°. An ice-bag was now applied over the whole left front of the chest, and on the morning of the next day (the fourth) the thermometer registered 98°. In the afternoon, however, it rose again to 105.8°. Examination showed that the resonance over the left front was remarkably improved, but fresh crepitation and bronchial breathing had appeared in the axillary region. The ice-bag was shifted to this region, and again the temperature fell to 98°. It rose once more to 103°, and fell again to 98°. On the fourth day of the ice-treatment there was another rise to 104.2°, which proved to be due to the implication of the opposite apex. A second ice-bag was applied here, and in twenty-four hours the apex was normal, and the temperature had fallen to 96.7°. After this convalescence was uninterrupted.

CASE XLII.—M., thirteen years of age, had pneumonia of the left base. The boy was first seen on the fourth day of the disease, when the temperature was 105.8° Five grains of quinine were given, and the next morning the temperature was only 100.6°, but in the afternoon it rose to 104.2°, when an ice-bag was applied over the inflamed lung. The rise continued until 6 P.M., when 105.4° was reached, and thereafter there was a gradual abatement until the seventh day, when the temperature was 99°, and the ice-bag was removed.

CASE XLIII.—F., twenty years old, was first seen on the seventh day of an attack of pneumonia of the right base, at which time her temperature was 104.4°, and an ice-bag was applied. There was a fall of three degrees during the next few hours, but on the following morning the temperature stood again at 104°, and remained between 103° and 104° for three days. On the tenth day it suddenly fell to to 98°, and the ice was removed. On the eleventh and twelfth days the pyrexia rose to 102°. Examination now showed a fresh inflammation at the base of the opposite lung. The ice was applied to this spot, and in three days the physical signs had disappeared, and the woman was convalescent.

CASE XLIV.—M., twenty-five years old, was admitted on the fourth day of an attack of pneumonia of the right apex, and was seen first on the following day, with a temperature of 103.6°, and in a semi-maniacal condition. An ice-bag was applied to the chest, and on the evening of the eighth day the temperature dropped to 99°, and the ice was removed.

CASE XLV.—F., twenty years old, was seen first, with pneumonia of the right apex, on the fifth day, and with a temperature of 104°. By the next morning the ice had depressed the temperature to 100°, but during the day it rose to 102°. The respiration now rose to 74, and some cyanosis appeared. It was found that the lung in front and behind was dull to the base of the angle of the scapula. On the next day (the seventh) the temperature was only 102.5°, but the respiration had risen to 100, and the right lung was involved throughout. Both cheeks were markedly cyanotic, and the expectoration was of a "prune-juice" character. The whole right chest was enveloped in ice, and the patient received four ounces of brandy daily, and a mixture of ether and ammonia every four hours. On the eighth day the temperature was 101.5°, but the respiration ranged from 88 to 100. On the ninth and tenth days the temperature remained about the same, but an extraordinary improvement occurred in the physical signs. On the latter day the temperature suddenly fell to 97°; the ice was removed, and convalescence supervened. "It must be allowed, I think," it is stated, "that in this case the ice was of the greatest service. It is hardly too much to say that it saved the patient's life."

CASE XLVI.—M., aged seven, had previously suffered from empyema, the right lung being entirely collapsed. The boy was first seen on the second day, when his temperature was 104°, and respiration 56. The pneumonia was believed to exist in the left lung, over which ice-bags were applied. The temperature fell four degrees before the next morning, but gradually rose somewhat during the subsequent forty-eight hours. On the third day the lips and cheeks were livid. This was not surprising, for the right lung was useless. On the fourth day the respiration was 60; on the fifth day the temperature was 102°, and respiration 58. On the seventh day the temperature fell to normal, and the ice-bag was removed.

CASE XLVII.—M., five years old, was admitted on the third day of his illness. The next day his temperature was 104°, and respiration 50. No signs of pneumonia could, however, be discovered until the sixth day, when it was found that the upper part of the right lung was consolidated. The ice-bag was applied until the eighth day, when crisis occurred.

CASE XLVIII.—M., about forty years old, had pleuro-pneumonia of the right base and pleurisy of the left side. On the second day the temperature was 104°, and respiration 32. The ice-bag was applied. Crisis occurred on the fifth day. This patient also had a very feeble heart. There followed a good recovery.

CASE XLIX. (Reported by Mr. Back, *Lancet*, August 29, 1885).—M., thirty-five years of age, was seized with double basic pneumonia May 31, 1885; the temperature was 104°, the respiration 48. Hot flaxseed-meal poultices were applied, and 5 ♏ of tincture of aconite, fl.ʒss of antimonial wine, and 5 ♏

of ipecacuanha wine were ordered every four hours, besides a diet of milk and beef-tea. On June 2d, the patient was much worse; the temperature was 106°, and the respiration 60; he was delirious, with profuse diarrhea, and was passing urine and feces involuntarily. On the 3d the diarrhea had ceased, but the man continued very delirious, and had a temperature of 106° and respiration 80. The whole chest was sponged with cold water every hour. On the 4th the temperature was 103°, the respiration 40, and the delirium was less. On the 5th the temperature was 100°, the respiration 34; the application of cold was continued. On the 6th the temperature was 99°, the respiration 30 From this time on the patient gradually convalesced.

CASE L. (Reported by Dr. F. Gundrum in THE NEWS, October 12, 1892, p. 473).—F., nineteen years old, suffered from pneumonia of the whole of left lung, with a temperature of 106° and a respiration of 46. On the first day the woman was wrapped, from chin to toes, in woollen blankets wrung out of cold water (50° F.), and changed every 30 minutes. At 1 o'clock the next morning the temperature was 102°; at 6 A. M., 98°, and respiration 16. She was now thoroughly rubbed, put in warm blankets, hot bottles placed about her feet, and half an ounce of brandy administered. This treatment aborted the disease completely.

The histories of these fifty cases open up many points of interest in the discussion of the influence of ice in the treatment of acute pneumonia, and as pertinent to this subject I will append the following comments:

1. *The resolving power of ice on the exudation.* This is a marked feature in its therapeutic action, and must be regarded as one of the strongest factors in its curative influence. This can at least be partly explained on the following basis: The most apparent lesion in croupous pneumonia is an enormous distention of the pulmonary capillaries, with partial or complete stasis of the blood in these vessels, exudation of the fluid constituents of the blood, and diapedesis of white and red blood-cells into the alveoli of the lung. It is well known that cold has the power of contracting the bloodvessels, and from this action one can understand why it should exert a beneficial action in pneumonia, by giving tone to the capillaries, by restoring the normal blood-flow, and thus checking the leakage. But there is often reason for believing that it also dissolves the exudate in the pulmonary alveoli. For example, there may be a pneumonic area in which there is absence of respiratory murmur, with the presence of a flat percussion-note and bronchial breathing—indicating, beyond doubt, that the process has passed beyond the stage of engorgement and into that in which the exudation has taken place into the alveoli; yet the application of ice will, in a remarkably short time, develop a new group of physical signs, such as crepitation, reappearance of the respiratory murmur, diminution of flatness, etc., indicating that a break-down occurred in the exudation. This has not only been observed by myself, but is dwelt on by Dr. Lees, who says (p. 894): "In many cases I noticed a striking arrest in the development of the physical signs," and that the ice-bag "distinctly tends to repress the inflammatory process in the lung."

Influence on symptoms. No less decided is the influence of the ice on some of the most prominent symptoms of pneumonia. The pain, difficult respiration, cough, and expectoration, are remarkably relieved, and the temperature is frequently depressed two or three degrees in the course of half a day. The beneficial influence exerted on these symptoms produces a very agreeable effect, and often makes the ice acceptable to those who, at first, protest against its use. This I have noticed in most of my cases, and it has also been witnessed by others, as will be seen by the histories of the cases that have been reported to me.

Is the ice injurious? My own rather limited experience with the ice-treatment does not show that it is accompanied or followed by any evil consequences, nor have any of those who have reported cases to me observed any such results, although some of them kept the ice applied for two weeks. Dr. Lees says (p. 894): "I have never seen any harm follow from the employment of the ice-bag in pneumonia."

Ages of patients. It is important to note in this collection that the ages of the patients in whose cases the ice was applied varied from infancy to old age—the youngest being six and a half months old, and the three oldest sixty, sixty-five, and seventy-four years respectively.

The results. It may be said, without claiming too much, that the results obtained from the ice-treatment of pneumonia have been good. Out of the fifty cases which I collected but two were fatal, making a death-rate of 4 per cent. In estimating this mortality-rate it must be remembered that at least one of the cases (XIII) that died was an exceedingly unpromising one, being a sufferer from chronic lead-poisoning, and also very intemperate; while the pneumonia which caused the death of the other one (XIV) was in all probability an acute exacerbation of an old attack. In Dr. Lees' series of eighteen cases (from XXXI to XLVIII) no deaths occurred, nor did any occur in the eleven cases reported by Dr. Jackson. Moreover, the *Lancet*, of August 10, 1892 (p. 279), refers to an article by Dr. Fieandt, published in *Duodecim*, a Finnish medical journal (an original copy of which I am unable to secure), in which there is an account of 106 cases of pneumonia treated with ice-applications by that gentleman, and notwithstanding that among

these there were ten cases of double pneumonia, and that the epidemic of the disease was rather severe, he had only three deaths, or a death-rate of 2.82 per cent. Adding these cases to those reported in my collection, we have a total of 156 cases of pneumonia treated by means of cold applications to the chest, with five deaths, or a death-rate of 3.20 per cent.

While the number of cases reported here is not very large, it is nevertheless evident that the results of the ice-treatment are much superior to any other with which I am familiar. Thus, according to Osler, the mortality-rate of 1012 cases in the Montreal General Hospital was 20 per cent., while in the Charity Hospital at New Orleans it was 20.01 per cent. Of 1000 cases of pneumonia treated in the Massachusetts General Hospital, from 1822 to 1889, the mortality was 25 per cent. In Dr. Hartshorne's valuable paper on "Pneumonia" it is estimated that the death-rate from this disease in the Pennsylvania Hospital during the years 1884, 1885, and 1886, was a little more than 31 per cent. In comparing the results of the ice-treatment, so far as they go, with those which have been obtained from the treatment pursued in the hospitals named, we find that the former are about eight times better than the latter. It will be of great interest to see by future clinical investigation whether these satisfactory results can be maintained, and if this can be done even approximately, it is needless to say that a pronounced advance in the therapeutics of acute pneumonia has been made.

COUGH OF NASAL ORIGIN, WITH REPORT OF A CASE.

BY MAXIMILIAN HERZOG, M.D.,
LARYNGOLOGIST AND OTOLOGIST TO THE GERMAN HOSPITAL, CINCINNATI, OHIO.

COUGH is, to a certain extent, a purely physiologic phenomenon, intended to support and supplement the action of the ciliated epithelial cells lining the respiratory tract. It is the function of these cells to keep up a current in the direction from the central organs of respiration—the lungs—toward the periphery, in order to remove the mucus secreted in the respiratory tract, and with it those mechanical adulterations, including pathogenic and non-pathogenic microörganisms, suspended in the surrounding air, that have gained access to the respiratory tract below the larynx by not having been effectually excluded by those organs especially equipped to do this, namely, the nasal cavities and the nasopharynx.

The act of coughing is considered physiologically as a modified expiration, brought about by reflex stimuli acting upon the pneumogastric nerve, more especially upon its branch, the superior laryngeal. The pneumogastric nerve is to be looked upon as the guardian of the lower parts of the respiratory tract, and, as such, has to prevent detrimental elements from gaining access to the lungs, or to remove by reflex action those that have already gained access.

The act of coughing usually begins with a deep inspiration; then follows an expiration, which is, however, obstructed, in consequence of the approximation of the vocal bands as tightly as possible (more completely than in phonation), by the adductor muscles of the larynx. At the same time the abdominal muscles force up the contents of the abdominal cavity and the diaphragm, which itself contracts; and the air in the alveoli, bronchi, and trachea, which cannot escape through the tightly-closed rima glottidis, is brought under a comparatively high pressure. Finally, the vocal bands relax, the air escapes forcibly, and its current, as it sweeps over the respiratory tract, carries along a certain amount of mucus and particles suspended in it, and, with the assistance of the muscles of the pharynx, etc., delivers it to the outside world.

In perfect health, and when surrounded by pure air, cough plays an insignificant rôle, very much subordinate to such physiologic processes as, *e. g.*, the act of micturition or that of evacuating the contents of the intestines. In many diseases, however, as, for instance, in croupous pneumonia, cough is the most important factor in ridding the alveoli and bronchioles of the pathologic products of disease. While a cough of this kind may be styled a necessary and beneficial reflex phenomenon, there are certain kinds of cough that are, from a physiologic as well as a pathologic point of view, of an absolutely useless character, dependent upon a reflex from a distant point, an irritation that, *de facto*, does not interfere, either sufficiently or not at all, with the act of respiration, and, therefore, cannot be favorably influenced by cough. Cases have been reported of cough of reflex origin from the liver and spleen (Naunyn), from the stomach and vesica urinæ (Krimer), from the external integument of the thorax (Leyden), from any and every part of the integument (Strubing), from the transmission of ordinary stimuli to the nerves of special sense (Ebstein)[1].

During the last ten years it has been generally recognized that the nose is among those organs that may give rise to most obstinate cough of reflex origin. That pathologic changes in the nasal cavities constitute one of the most fruitful sources of various reflex phenomena is a fact that has been recognized for some time. The first, however, to mention this more elaborately and to lay especial stress upon it

[1] Quoted in Gottstein, Die Krankheiten des Kehlkopfes, 1890.

was Voltolini,[1] whose views were afterward confirmed by reports of cases by B. Fraenkel, Hænisch, A. Hartmann, M. Schaeffer, Bresgen, J. Herzog, and especially Hack,[2] who reported a number of instances and advanced a theory in explanation of reflexes of nasal origin. While the theory of Hack has been almost completely abandoned, he may still claim the merit that his paper was the most complete and most extensive on the subject up to his time. Among Hack's cases of reflex neuroses of nasal origin was also one of reflex cough dependent upon the presence of a nasal fibroid polypus. Carl Seiler[3] followed with the report of two cases of reflex cough of nasal origin. John N. Mackenzie[4] next recorded his experiences on the subject. Thrasher[5] reported two cases before the meeting of the Mississippi Valley Medical Association, at Louisville, in 1890. One case is also reported by Scheinmann,[6] who tabulates and reports thirty-two cases of reflex neuroses of nasal origin occurring at the Throat and Nose Clinic of the University of Berlin, and whose extensive paper is undoubtedly the best contribution upon the subject which has appeared during recent years. Whether F. C. Heath, who contributes a paper on "Nasal Reflexes," in the *American Lancet*, Detroit, 1891, reports any new cases of reflex cough of nasal origin I am unable to state, as his paper has not been accessible to me.

Many of the authors who have written upon the subject of reflex neuroses of nasal origin point out the fact that it is almost universally in patients of a neurotic taint that these neuroses develop. Under some conditions the nasal cavities may show extensive pathologic changes; there may be new growths and points and surfaces compressing each other, without the appearance of any reflex phenomena. On the other hand, in individuals of anemic and neurasthenic type, slight changes, small areas of contact may bring about serious reflex disturbances. Some authors go as far as to maintain that no changes in the cavum narium of the kind usually producing reflex neuroses will do so unless developed upon the soil of an already disturbed nervous equilibrium.

If the normal nasal mucous membrane of an individual in perfect health, at the time not the subject of cough, and not accustomed to a prolonged course of nasal treatment, be gently irritated by a nasal sound, one will almost universally notice a twitching of the facial muscles of the side touched, a dilatation of the vessels of the nasal mucous membrane, and epiphora. If the irritation be more intense (such as may be caused by a weak electric current), sneezing, and, very often in nervous individuals, coughing will be excited. This observation is in favor of the claim of those who maintain that reflex neuroses of nasal origin only or almost universally develop on a neurotic soil. The case herewith reported may also be cited in support of this view:

M. B., an unmarried girl, twenty-one years old, of good family history, was said to have had "curvature of the spine" when she was four or five years old, for which she was treated, and got well. She suffered occasionally with pain in the back. For two or three years she had had a constant cough with a feeling of irritation and a sensation of the presence of a foreign body in the throat, of which she wanted to get rid. All treatment directed against the cough had failed to benefit her and ameliorate the constant irritation. The patient also stated that she sometimes had pain in swallowing, and had been told that she breathed through her mouth during sleep, though she did not snore. The sense of smell had always been good.

The girl was small and slender, looking less than her years. She limped slightly in walking, in consequence of a deformity of the spinal column in the lumbar region (probably a scoliosis—no direct examination of the spine having been made), and was anemic, restless, and nervous.

The nasal mucous membrane was rather pale and anemic, and in a few discrete spots appeared atrophic. In the left nasal cavity, about three centimeters behind the anterior nares, close to the floor, was a mucous band, connecting the lower turbinated bone with the septum, stretching across and largely obliterating the inferior meatus. This band was from 3 mm. (at its middle part) to 5 mm. (at the two points of attachment) wide and of the same color as the neighboring parts. On the right side the mucous membrane of the lower turbinated bone showed some hypertrophy. The posterior extremity of this structure also showed a slight amount of thickening. Tenacious mucus covered the roof of the naso-pharynx. The pharyngeal mucous membrane was granular; on either side two granular bands extended from the plicæ salpingopharyngeæ downward; the band on the right side being especially well marked. Both tonsils were somewhat hypertrophic, the right one especially so. The epiglottis was imbedded in a hypertrophic lingual tonsil; the larynx was otherwise normal.

A diagnosis was made of adhesion in the left inferior nasal meatus, with chronic granular and lateral pharyngitis, and hypertrophy of the pharyngeal and lingual tonsils.

In view of the numerous hypertrophies found in the pharynx, it seemed justifiable to consider them as the cause of the cough, and they were consequently treated topically for a long time. The band of adhesion in the left nasal cavity was, on ac-

[1] Voltolini: Anwendung der Galvanokaustik, etc., Wien, 1871.
[2] Hack: Berl. klin. Wochenschr., 1882.
[3] Archives of Laryngology, vol. iii.
[4] Amer. Journ. Med. Sci., July, 1883.
[5] Cincinnati Lancet-Clinic, October 11, 1890.
[6] Scheinmann: "Zur Diagnose und Therapie der Nasen Reflexneurosen," Berl. klin. Wochenschr., 1889, pp. 295, 327, 399, 425, 471.

count of its situation and color, readily overlooked, and was only discovered when the patient came to my clinic. Touching the mucous band connecting the lower turbinated bone with the septum did not excite a fit of coughing. This observation did not, however, at all influence me in my belief that in the adhesion I had found the cause of the reflex cough. It has frequently been noticed that pathologic changes in the nose act as the cause of reflex neuroses that disappear after proper surgical interference or other therapeutic measures, even if, on touching these structures or tender points, as the case may be, the reflex is not always excited. The result of such interference in the case reported in this paper proved the correctness of the assumption.

Two days after the examination the lower parts of the left nasal cavity were treated with a ten per cent. solution of cocaine, and the band of adhesion, which now appeared very much on the stretch, was divided by a galvano-cautery platinum knife. No pain was experienced, and no hemorrhage followed. Insufflation of europhen was practised after the operation.

On the following day the patient reported that the cough had disappeared completely. The good effect continued. A ferruginous tonic was prescribed, but the pharynx was not touched.

The nasal mucous membrane at the points of cauterization healed kindly; the cough did not reappear.

The patient, after taking iron for some time, felt better than she had for years. She looked well, had gained in weight, and her cheeks presented a rosy color. The hypertrophies of the pharynx still persisted, as they had not been interfered with surgically. The cough, which had left the patient directly after the operation, had not reappeared.

The case is instructive not only as one of cough of nasal origin, but also because it shows that hypertrophies in the pharynx, which often give rise to reflex symptoms, may not do so, even in a nervous subject in whom structural changes (in our case an obstructive adhesion) in the nose will do so.

In conclusion, I would like to state that it is my belief that the adhesive band in this case originated from ordinary hypertrophies, such as are found in almost every case of rhinitis hypertrophica. Probably a point of contact was established between the mucous membrane of the turbinated bone and that of the septum, a slight ulceration occurred in consequence of the hypersecretion dependent upon the hypertrophy, and the adhesion was formed at the point where two ulcerated surfaces were in contact. Later on the hypertrophy underwent a retrograde change (there being, already, spots of a somewhat atrophic character noticeable at the time the patient presented herself), and the mucous membrane contracted, but left behind a band of adhesion at the place that formerly had been a point of contact, the band acting as a source of reflex cough.

No. 50 W. NINTH STREET.

CLINICAL MEMORANDA.

TRAUMATIC EMPYEMA COMMUNICATING WITH THE BOWEL.[1]

BY N. T. DULANEY, M.D.,
OF BRISTOL, TENN.

E. G., thirty years old, a conductor on a freight train, while engaged in the discharge of his duties was shot with a 38-caliber pistol at short range, the muzzle of the pistol being within a few inches of his body. The ball entered his body in front, at a point about five inches below the left nipple, and one inch and a half outside the left nipple line. The ball could not be located for several weeks. I saw the patient nearly a month after the reception of the injury, in consultation with his attending physician, Dr. M. M. Butler, of Bristol, Tenn. I learned that the patient had not had very much fever, the temperature varying from 99° to 101°; the pulse from 90 to 100, and not sthenic. When I saw the man the temperature was 102°. There was very little pain; no cough, nor had there been any at any time; no bloody expectoration to indicate a wound of the lungs; little or no appetite. The bowels were torpid; the breathing somewhat hurried and more pronounced on the right side. The patient was considerably emaciated.

Physical examination revealed extensive dulness over a large portion of the left chest, amounting to flatness, with absence of normal respiratory sounds, and increased percussion-resonance and exaggerated respiratory murmur on the right side. The case not improving, but symptoms of septicemia becoming more pronounced, I was again called twelve days later. Physical examination disclosed the same condition as before, but somewhat aggravated and with the addition of a distinct prominence as large in circumference as the mouth of an ordinary teacup, situated on the back, to the left of the spine, and corresponding to the eighth and tenth ribs in this region. With this as a guide, the patient was anesthetized and a vertical incision about three inches in length made through the prominence, down to the ribs. There was now a gush of very offensive, dark fluid, amounting to about a quart, which seemed to be a mixture of serum, pus, and the *débris* of disintegrating tissue.

The ball was found just outside the chest under the deep muscles of the back, in its passage having broken a rib—the tenth, I think—about one and a half inches from the spine. A portion of the same rib was broken, but not detached, for a distance of about an inch, and was hanging loosely in the chest in such a way as to obstruct the opening in the chest-wall. This being removed with forceps, the opening was at once filled by a mass of dead tissue forcing its way out. I began drawing this out and continued until no more came, when I had as much as I could hold in my two hands. It was a stinking mass of dead tissue, consisting, I think, of pleura and lung and connective tissue. It was dark, almost black, thickly covered with grayish, ash-colored spots as large as a wheat grain and larger. Having removed all of this dead tissue, the cavity was washed

[1] Read before the Tennessee State Medical Society, April 11, 1893.

out with a weak, warm solution of carbolic acid, and the wound dressed with iodoform-gauze, absorbent cotton, and bandage, and the patient quieted with a dose of morphine hypodermatically. The temperature steadily declined, the wound being dressed every day and the cavity washed out with warm water, usually with a little carbolic acid added.

The day after the operation we used an enema to evacuate the bowels. The nurse, a negro man, said that the water of the injection passed out through the opening in the back. This being doubted, the physician in charge tested it the next day by injecting into the bowel water colored with potassium permanganate, and he found that the fluid injected into the rectum passed freely and promptly out through the opening in the back. This was an unexpected and perplexing complication.

From this time on the wound was dressed and washed out every day for some weeks, and for three or four months fecal matter passed out through the wound freely, especially when the discharges were thin.

Two months after the accident I dressed the wound, and a mass of fecal matter as large as a hulled walnut passed out. The patient slowly but steadily improved, and is to-day on duty as a railroad conductor, looking well and weighing 193 pounds, the fistula having entirely closed.

This is an interesting case, because:

1. There were no rational signs pointing to injury of the lung. There was no blood expectorated, no cough, and at no time was the sputa characteristic of pneumonia. The case went on for seven weeks, the chest filling with serum and pus, and a large amount of tissue undergoing necrosis within the chest. Yet, aside from the physical signs and the altered breathing, there was nothing to indicate the exact nature of the case. It is true, the persistent fever, emaciation, loss of appetite, restlessness, and failing strength indicated something seriously wrong, but it remained for the physical examination to determine the nature of the condition.

2. The ball in its passage had so damaged the diaphragm and the bowel at some point in contact with it as to lead to inflammatory adhesion, followed by sloughing, and resulting in a fecal fistula. With all this, there was no bloody or mucous discharge from the bowels, and no symptoms indicating injury of the bowel until the water injected into the rectum was seen to pass out through the wound in the back.

In regard to the management of this case, while no new principle is involved, the result forcibly emphasizes the two or three main points in the local treatment of such cases, whether of idiopathic or of traumatic origin —namely, cleanliness, or antisepsis, if you please, with thorough drainage. These given, unless your patient is exhausted from protracted disease, or septicemia, or some undermining constitutional disease, you are in most cases warranted in making a favorable prognosis.

It is astonishing how promptly convalescence sets in after the inauguration of such treatment, if not too long delayed, or if the ordinary *vis medicatrix naturæ* is present to assist you. Of course, constitutional treatment, based on general principles, is not to be neglected.

The distance from the point of entrance of the ball to the point where it was cut out around the chest is eight and three-quarters inches.

CYSTIC DEGENERATION OF ENLARGED SUBMAXILLARY GLANDS.

BY D. W. HAYS, M.D.,
OF OSAWATOMIE, KAN.

MRS. B., born in 1819, when about thirty years old noticed a "kernel" under the right jaw, which, however, did not subside in the usual manner, but continued to slowly enlarge, though it remained freely movable. It gave no inconvenience or pain, and only after it had attained considerable size was anything done to check its growth or produce its absorption. Then, only local applications of tincture of iodin and the like were used until 1871, when the mass had become a little larger than a man's fist. A diagnosis of multilocular cyst was made, and removal advised. The opinion was expressed that the growth would not undergo further enlargement, or shorten the woman's life, and she therefore refused operative interference. Contrary to prediction, the mass continued to increase in size, and even more rapidly than before, so that at the time of death, Nov. 19, 1892, at the age of seventy-three years, it measured fifty inches in circumference and, after removal, weighed forty-seven pounds.

The mass was easily removed, being encapsulated and attached only to the integument and connective tissue. The superficial veins were numerous and quite large; the arterial supply was small, and the vessels were not traced to their origin. One large branch from the facial nerve, with numerous dividing branches, was found on the upper part; other nerve-supply was not sought. The inferior maxillary bone had been pushed or dragged forward, and had been absorbed from below until it presented a decided upward curve.

The contents of the tumor were found to be a greenish-yellow fluid. The walls were, at some portions, thinned until they were little more than half an inch thick; at no

place were they more than an inch and a half thick. The tissues of the walls seemed to be thoroughly disintegrated and of a cheesy consistency. A section from the apparently best organized portion showed nothing distinctive under the microscope, except some broken-down glandular tissue.

The accompanying photograph was taken some eight or ten years ago, and does not show the actual size at death; it would have shown better if it had been suspended.

I think this case worthy of record on account of the large size and situation of the growth, and especially because of its evident origin, as it is quite certain, from the best history that I can obtain of its commencement, that it was an enlargement of one of the submaxillary glands that became cystic by degeneration.

MEDICAL PROGRESS.

A Case of Diphtheric Croup in which a Tracheotomy-tube was Worn for Sixty Days.—At a recent meeting of the Philadelphia Academy of Surgery, DR. H. R. WHARTON reported the case of a child eighteen months of age, with diphtheria, in which an intubation-tube was introduced for the relief of dyspnea. At the end of fifteen hours the instrument was coughed up and the dyspnea returned. Tracheotomy was then performed, with relief to the dyspnea, and the patient subsequently did well.

On the tenth day after the operation the tracheotomy-tube was removed and the patient breathed comfortably for a time, but after fifteen or twenty minutes the dyspnea recurred and became so urgent that the tracheotomy-tube had to be replaced.

Attempts were made to remove the tube at intervals of a day or two for a week or more, with a similar result. Four weeks after the operation the child was etherized and the tracheotomy-wound was dilated, so as to expose the wound in the trachea. It was then found that there were a number of masses of granulation-tissue springing from the trachea in the region of the tracheal incision; these were removed with forceps and scissors, and the tracheotomy-tube was again introduced. After waiting a few days another attempt was made to remove the tracheotomy-tube, but this also failed. An intubation-tube was introduced upon the removal of the tracheotomy-tube, and was worn for some hours, and upon its removal the child was able to breathe comfortably for five hours; but after this time dyspnea recurred, and the tracheotomy-tube was again introduced. After several trials of the intubation-tube, it was finally abandoned. The patient was again etherized, the tracheotomy-wound enlarged, and a number of masses of granulation-tissue removed, and their bases were touched with the solid stick of silver nitrate. An intubation-tube was then introduced, and was worn for twelve hours, when it was coughed up. Thinking its expulsion was probably due to the irritable condition of the larynx and trachea, resulting from the recent operation, the tube was not replaced for forty-eight hours. To keep the tracheotomy-wound open, so that the tracheotomy-tube could be introduced, if it were required, an obturator was introduced into the tracheotomy-wound. The intubation-tube was worn for four days and was then removed, and the obturator was retained in the tracheotomy-wound for three days longer, and was then removed. The child after this time had no further difficulty in breathing, and the tracheotomy-wound, after the removal of the obturator, rapidly contracted and healed. The patient wore the tracheotomy-tube for a period of sixty days.

Rupture of the Uterus during Labor, with the Placenta in the Abdominal Cavity.—WASTEN (*St. Petersburger medicin. Wochenschrift*, No. 19, 1893, p. 173) has reported the case of a woman, twenty-nine years old, who was delivered of her ninth child with the aid of forceps, after a not unduly protracted or difficult labor. The child was dead. The placenta had not been expelled. Examination showed the uterus to be contracted, but the placenta was in the abdominal cavity. Notwithstanding the precarious condition in which the woman was, celiotomy was undertaken. Cocaine was injected in the line of the contemplated incision and chloroform was cautiously administered. The portion of the umbilical cord in the vagina was cut away, and the placenta, with numerous blood-clots, was removed from the abdominal cavity. Then the uterus was amputated above the vaginal portion and the broad ligaments and large vessels ligated. The stump was gently cauterized with the hot iron and replaced in the abdominal cavity. Drainage *per vaginam* was provided for and the wound closed. Convalescence was attended with no noteworthy complication, other than the occurrence of an endometritis in the remaining portion of the cervical canal and the formation of an exudate in the right iliac fossa. It was found that the rupture had involved the anterior wall of the uterus in the situation of the placental insertion. It is thought to have taken place spontaneously.

Qualitative Variations in the Knee-jerk.—BENEDIKT (*Neurologisches Centralblatt; Deutsche medicin. Wochenschr.*, No. 19, p. 464) describes four varieties that the knee-jerk may present: (1) It may be clonic; several jerks rapidly succeeding one another after a single tap upon the tendon. This may occur in cases of palsy, of myelitic or cerebral origin, and with spastic conditions of spinal origin. (2) The knee-jerk may be paradoxic, the leg being jerked in flexion instead of in extension. This has been observed in a case of tumor of the roof of the fourth ventricle at the level of the striæ acusticæ, presenting headache, static vertigo, and unilateral nervous deafness, to which melancholic apathy was subsequently added. A sub-variety of this form consists in the occurrence of a flexor jerk following the extensor jerk. (3) Percussion of the quadriceps tendon is in some cases followed by contraction not only of the extensors or flexors of the knee, but also of some of the muscles of the trunk and of the opposite side of the body. (4) The knee-jerk may be tonic; the leg is slowly extended, but fails to fall back to its original position. There is, however, no actual spasm of the quadriceps. In cases of marked lateral sclerosis, with greatly increased reflex irritability, percussion of the quadriceps may induce tonic extensor or flexor spasm. (5) The knee-jerk may be delayed; or (6) it may become exhausted.

Primary Sciatica.—GIBSON (*Lancet*, No. 3633, p. 860) has reported the results of an analysis of 1000 cases of

primary sciatica, with especial reference to the treatment of 100 cases by acupuncture. Of the whole number, 884 cases occurred in males; 116 in females. In 443 the right side, in 483 the left side, and in 74 both sides were affected. In 14 cases the affection was first observed between the ages of 15 and 20; in 159, between 21 and 30; in 310, between 31 and 40; in 248, between 41 and 50; in 187, between 51 and 60; in 71, between 61 and 70; in 11, between 71 and 80. In 132 there was accompanying lumbago. Of 100 consecutive cases of sciatica treated by accpuncture, 56 were cured, 32 were much improved; 10 were improved; and 2 were not improved. A single spear-pointed needle two and a half inches long, was employed. This was plunged into the nerve itself, but immediately withdrawn. The nerve should be pierced about five times over the parts where there is pain on pressure; this can be accomplished through one cutaneous puncture by partially withdrawing the needle and entering it again at a somewhat different angle. A single puncture may suffice. The measure may, however, be repeated at intervals of a few days. Rest is an essential factor in the treatment. A gouty or a rheumatic diathesis should receive appropriate attention.

Renal Hematuria, Lasting Twenty Years.—WETMORE (*Maritime Medical News*, vol. v, No. 5, p. 65) has reported the case of a man, sixty-four years old, who for twenty years, intermittently, passed blood in the urine. The first attack occurred in the winter, without known cause, and lasted for two months. The second attack occurred three or four years later, and also commenced in the winter and lasted for two months. The attacks gradually became more frequent and lasted longer, the urine for six years not having been free from blood for more than a few weeks at a time. There was no family history of carcinoma or tuberculosis, and no personal history of malaria. There had never been colic. In some attacks there were pain and tenderness in the right loin and pain and swelling in the right hip and lower extremity, and swelling of the left lower extremity. The urine contained a moderate amount of albumin and many red blood-corpuscles and some blood-casts. An ultimate diagnosis was not arrived at.

Acute Pulmonary Hypertrophic Osteoarthropathy.—At a meeting of the Société Médicale des Hôpitaux, MOINARD (*La Semaine Médicale*, No. 13, 1893, p. 247) reported the case of a child, six years old, which three months after an attack of meta-pneumonic purulent pleurisy, presented deformity of the terminal phalanges, characterized by lateral thickening of the extremities of the fingers, which looked like drum-sticks. The nails were curved longitudinally and transversely like a parrot's beak or a watch-glass. They were abnormally deep red in color and extremely friable, but not striated. There was no other bony lesion. A second case occurred in a girl of five. The sequence and the lesions were quite like those in the first case, and the deformity disappeared with the cure of the pleuro-pulmonary condition.

MARFAN related that he had observed three cases of similar kind; one of empyema, one of bronchiectasis, and one of pyelo-nephritis.

THERAPEUTIC NOTES.

The Treatment of Suppurating Tuberculous Tissues.—A new treatment for suppurating tuberculous tissues has lately been suggested by JEANNEL, of Toulouse. The diseased tissues are freely exposed and, after the surrounding healthy parts are protected by a damp towel, the diseased structures are thoroughly sponged with a tampon of hydrated cotton-wool previously placed in a boiling saline solution. The application should be made to all irregular surfaces. After the procedure has been repeated five or six times it may be concluded that all of the tubercle-bacilli present have been brought into contact with the boiling solution, and have thus been destroyed. It is stated that this method has been employed in some cases in which amputation seemed to be the only remaining resource, with a satisfactory result and without mutilation.—*Medical Press and Circular*, No. 2820, p. 547.

Bromoform-intoxication.—DEAN (*Lancet*, No. 3636, p. 1062) has reported the case of a girl, four years old, with whooping cough, for whom was prescribed a four-ounce mixture, containing sixty minims of bromoform, and of which it was directed that two drams should be taken every three hours. In the course of the treatment the physician was hastily called to see the child and found it with pin-point pupils, livid, and breathing somewhat stertorously. On inquiry it was learned that the attendants had failed to thoroughly shake the mixture before its administration, and that, as a consequence, the child had received with the last dose from the bottle about fifteen or twenty minims of bromoform. The stomach was evacuated by means of a pump, the contents smelling strongly of bromoform. Strong coffee was injected into the bowel, and a small dose of apomorphine injected beneath the skin, and the battery employed. The child slowly recovered and was shortly quite well.

For Tuberculosis.—

℞.—Iodoformi . . . . . gr. xx–xl.
Essentiæ eucalypti
Essentiæ terebinthinæ
Essentiæ guaiaci
Creasoti . . āā ʒj.—M.

S.—By inhalation or spray; or from five drops upward
PETRESCO, *La Roumaine Méd.; Münch. med. Woch.*

Calomel for Gout.—GRIMM (*Deutsche medicin. Wochenschr.*, No. 17, 18; *Wiener medicin. Presse*, 1893, No. 2, p. 818) has successfully employed calomel in a single large dose, in the treatment of acute and subacute gout. The result is ascribed to the stimulation of peristaltic activity, as it is known that an attack of gout is often preceded by intestinal torpor. Yellow mercuric iodid was found to act even more energetically than calomel.

To Allay the Craving for Alcohol.—

℞.—Tinct. capsici . . . . fʒij.
Tinct. nucis vomicæ
Acid. nitrohydrochlor. dil. āā fʒj.
Infus. gentian. . . ad fʒxij.—M.

S.—Two tablespoonfuls as required.

The Practitioner.

THE MEDICAL NEWS.

A WEEKLY JOURNAL

OF MEDICAL SCIENCE.

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SATURDAY, JUNE 24, 1893.

THE REPORT OF THE COMMITTEE ON REVISION OF THE CODE.

THE MEDICAL NEWS cannot agree with either the arguments or the recommendations of the majority of the Committee on Revision of the Code of the American Medical Association, in so far as these apply to the regulations governing the conduct of physicians. We have already stated our belief that the paragraphs referring to the conduct and obligations of others than physicians have no proper place in the Code; and in this we are at one with the majority of the Committee. When, however, that majority recommends that physicians should be permitted to patent mechanical devices, and to consult with all "legalized practitioners," we must emphatically dissent. On these two propositions the coming battle is to be fought; and the lines should be distinctly drawn.

As to the patenting of instruments, the objections are many; and the alleged parallel with copyrighting of books does not hold. The relation of an author to his readers is that of teacher to pupil. He devotes much time and study to research, literary and otherwise, and expresses the results in a certain manner. For this he receives a compensation, often quite inadequate to the labor performed. [We are speaking now, of course, only of the best books; not of the books written with paste-pot and shears.] That compensation is exactly parallel with the fee paid lecturers and demonstrators by their pupils. It differs from a royalty on a patent in that it is not paid for *permission* to do certain things, but for *instruction* how to do them. For example, one might pay a fee for instruction in the performance of intubation; but this would be very different from a royalty on the instruments used.

The copyright has a further most important aspect, as security to the publisher that, having expended certain sums and incurred large risks in the preparation of a book, his investment shall not, in case the book proves successful, be stolen by others who have taken no risk. Beyond this, too, it protects an author from misrepresentation through careless book-making or unauthorized omission or addition; and thus protects the student from being misled.

Patents, on the other hand, are in the nature of tribute. They have invariably a tendency to unduly increase the cost of an instrument, to restrict its application, and to prevent its improvement. The only thing to be urged in their favor is the increased revenue to the owner of the patent. No better illustration of the purely commercial purpose of patents can be given than the history of the "pneumatic cabinet," for which at first a yearly rental was demanded equal to the sum for which the apparatus was afterward sold outright when its claims were found to be exaggerated.

If the sole purpose of the medical practitioner is to make all the money possible out of medicine, then let him patent his instruments, as any other tradesman would. Let him also patent his prescriptions if possible; for there is no essential difference, moral or intellectual, between altering the curve of a knife-blade and altering the proportions of calomel and jalap in a powder. The true parallel is that between patented medicines and patented instruments; not between patented instruments and copyrighted books.

Should the wise restriction of the Code be abrogated, what a delightful time we can expect when Professor Biggun hauls Doctor Greathead into court for infringing the patent of his obstetric forceps or his nasal cotton-holder. The "Priorität-streiten" of our Continental colleagues will sink into insignificance. And what a field for expert testimony! If Professor Biggun's students should swear that he lectured on the instrument in 1880, who knows but

that Doctor Greathead will exhibit a picture of it in an Italian tome of 1654?

Supposing the physicians of America to be anxious to lose all dignity and self-respect in a mad scramble for the Almighty Dollar, certainly there is but one means more effectual than the patenting of mechanical devices, and that is offered by the proposed provision as to consultations.

The special plea of the majority of the Committee that to consult with an irregular does not mean to hold a regular consultation equals in logic and humor the old conundrum which declares a door not to be a door when it is ajar.

We are not opposed to specialists or specialism; we believe in both; but we are opposed to that narrow view which places the specialist as a god upon a pedestal of superior wisdom, and makes the family physician but a nurse, or at best a clinical clerk who rehearses a history. No specialist worthy the name but consults with the attending physician, actually as well as nominally. If any refuses to do this, he is an excellent man not to send patients to. The attending physician is the one responsible for the management of the case, whether his consultation be in a case of cataract, or a case of ovarian tumor, or a case of enteric fever. He selects the consultant in each instance for the latter's special knowledge and experience in that particular class of cases. And whether the outcome of the consultation be an operation by the surgeon or the bathing of the patient by the nurse, in each instance the one who performs the work does so as the agent of the attending physician and by his consent and direction.

Such being the case, no loophole of escape from the full meaning of consultation can be found in the case of a specialist treating the patient of an irregular practitioner in professional association with the latter. The irregular is the responsible attendant, the specialist is his agent in performing the necessary manipulations. There is no other possible view. We have on other occasions shown why this or any professional relation with quacks or sectarians is unwise and immoral. While for the present merely referring to our former utterances, we may at some future time recur to the subject, for the reason that instruction upon the issues involved seems to be needed.

We trust that those interested in the preservation of professional purity will act on the advice of PRESIDENT MCGUIRE and secure discussion and formal expressions of opinion in their respective County and State societies, in ample time to influence in the right direction the action of the American Medical Association at its next meeting. Those who wish the door ajar for unrestricted consultations will certainly be active and wary; those opposed to this degradation should be no less so.

NEPHRITIS OF MALARIAL ORIGIN.

As our knowledge of disease-causes grows, our perception of disease-complications correspondingly enlarges. It is thus that the number of so-called idiopathic affections becomes constantly less.

It is only since the studies of LAVERAN have incontestably shown that malarial disease is dependent upon the presence of parasites in the blood, and since we have by direct observation and by analogy become familiar with the biology of these minute organisms, that we have learned to recognize and understand the complications and sequelæ of an important group of diseases. While this knowledge has added nothing to our therapeutic resources, it has placed upon a rational basis a method of treatment that, however successful, has hitherto been purely empiric.

We are now fully able to appreciate why anemia should be so common a manifestation in the course of malaria; why under certain conditions of virulent intensity the pernicious forms should terminate fatally; why under other conditions thrombi should form in the bloodvessels and give rise to symptoms as variable as the organs in which the morbid process takes place. By the gradual accretion of knowledge of this kind we are prepared for the announcement that malarial infection may give rise to nephritis. Of this interesting association three instances are reported by STEFANOWICZ (*Wiener klin. Wochenschr.*, No. 20, p. 365). In each the subject had lived in a malarious region; specific organisms were found in the blood; all of the symptoms, including the presence in the urine of albumin and casts, disappeared upon the administration of quinine in antiperiodic doses.

Three explanations of these remote or secondary complications of malaria at once suggest themselves: First, a toxic process; second, thrombosis; third, hemorrhage. Without here entering into a discussion of the various possibilities in the case, we venture to express the view that the first proposition is that which in most cases best explains the conditions present. There is much reason to believe

that in diseases of malarial origin toxic products are set free in the circulation, primarily as a result of the activity of the parasites present, and secondarily as a result of their destructive influence upon the red blood-corpuscles.

The subject is one of practical interest, and worthy of further study. In this connection it is interesting to note that methylene-blue has already been recommended in the treatment of nephritis as well as of malarial disease.

EDITORIAL COMMENTS.

Stretching of the Facial Nerve for the Relief of Trigeminal Neuralgia.—Among the most obstinate of intractable affections are the neuralgias, and of these perhaps the most intractable is that of trigeminal type. At the recent German Surgical Congress, SCHULZE-BERGE (*Deutsche medicin. Wochenschr.*, 1893, No. 22, p. 535) detailed a mode of treatment which, despite the admonition of some distinguished men present, still appears to have much to commend it, and to be deserving of trial before resort to major measures. The procedure consists in stretching the facial nerve of the affected side, in the hope of removing a source of irritation dependent upon the functional activity of this nerve. This practice was carried out in the case of a woman who had suffered for six years from neuralgia of the third branch of the trigeminal nerve, and in which extirpation of the buccal nerve had been unattended with relief. The pain ceased after the fifth day. In the subsequent discussion, Esmarch and Gussenbauer maintained that the stretching should not be performed until other measures, including a course of castor oil, had failed. König pointed out the possibility of permanent paresis as a result of the operation.

The Etiology of Friedreich's Ataxia.—While there is practical unanimity of view as to the clinical history of the affection described by Friedreich and known by his name, or in consequence of deficient knowledge, as hereditary ataxia, there is some diversity of opinion as to the pathologic basis of the disorder. The prevalent view is that the symptoms depend upon sclerosis of the posterior and lateral columns of the spinal cord, though the factor of heredity is probably as often absent as present. SENATOR (*Berliner klin. Wochenschr.*, 1893, No. 21, p. 489) reports a typical case, but dissents from the current view of its pathology. He presents facts and advances argument to show that the symptoms are to be referred to a congenital defect of development of the cerebellum, to which the changes in the posterior and lateral columns may be secondarily added, but are not essential.

Professional Confidence.—*A propos* of our recent remarks on the sanctity of the confidence reposed by patients in physicians (THE NEWS, April 22, 1893, p. 439), it is interesting to note that a bill has been introduced into the Canadian Legislature to place the physician in this connection in the same category as the lawyer, and to regard as privileged confidential communications between patient and physician.

Similar legislation, it appears, has already been enacted in New York and in Michigan. In France it is penal for a priest, lawyer, physician, druggist, or midwife to reveal information into possession of which he or she may have come in the course of professional duty.

Bacillus Aërogenes Meningitidis.—In the cases of cerebro-spinal meningitis hitherto studied from a bacteriologic point of view, the pneumonia-coccus (micrococcus lanceolatus) is the organism that has been most frequently found present. In two cases recently studied, an Italian observer, Centanni, has found exclusively an organism to which he gives the name bacillus aërogenes meningitidis.

Ecphyaditis is the name proposed by Dr. Robert T. Morris as a substitute for appendicitis. The word is a good one, as the term ecphyas already exists in medicine to describe the appendix vermiformis ceci. Ecphyaditis is also philologically the preferable word; it has the further advantage of distinctiveness.

REVIEWS.

THE TWELVE TISSUE REMEDIES OF SCHÜSSLER, COMPRISING THE THEORY, THERAPEUTIC APPLICATION, MATERIA MEDICA, AND A COMPLETE REPERTORY OF THESE REMEDIES, HOMEOPATHICALLY AND BIO-CHEMICALLY CONSIDERED. By WILLIAM BOERICKE, M.D., late Professor of Materia Medica in the Hahnemann Hospital College of San Francisco, etc.; and WILLIS A. DEWEY, M.D., Professor of Materia Medica in the Hahnemann Hospital College of San Francisco, etc., 3d edition. Rewritten and enlarged. 8vo, pp. 384. Philadelphia: Boericke & Tafel, 1893.

THE remarkable confusion of terms exhibited in the title of this volume is an index of the confusion of thought that pervades it. It is possible for one to honestly believe the dogmas of homeopathy; but not to believe those dogmas and at the same time to think clearly. It seems that one Dr. Schüssler, of Oldenberg, Germany, in 1873, published an article entitled: "A Shortened Homeopathic Therapeutics," in which he undertook to prove that all diseases curable at all were curable by the administration in infinitesimal doses of those mineral substances that form part of the normal animal body. The "Twelve Tissue Remedies" are "ferr. phos., calc. phos., natr. phos., kali phos., kali mur., natr. mur., calc. fluor., silicia, calc. sulph., natr. sulph., kali sulph., magnes. phos." By a table published on page 29, we see that these salts are constituents of various other drugs, such as "china, gelsem., berb. vulg., hamam., cimicif., coloc.," etc., etc. From all of which, by pure Hahnemannian logic, it follows that Schüssler is right in his practice, but wrong in claiming, as he now does, that he has gone beyond homeopathy, and founded a *new* "new school" of Bio-chemiopathy—or something of the sort. There are several practical wheat-kernels in this barnful of chaff, but the result is not worth the labor of winnowing.

LECTURES ON MENTAL DISEASES, DESIGNED ESPECIALLY FOR MEDICAL STUDENTS AND GENERAL PRACTITIONERS. By HENRY PUTNAM STEARNS, A.M., M.D., Physician Superintendent of the Hartford Retreat, Lecturer on Mental Diseases in Yale University, etc. With illustrations. Pp. 627. Philadelphia: P. Blakiston, Son & Co., 1893.

THIS volume consists of twenty-nine lectures, which the author delivered before the students of Yale University, and covers the field of mental diseases. The tone of the lectures is conservative, representing, for the most part, the consensus of opinion of American alienists. The classification of insanity is not so extensive as that adopted by Spitzka and other modern writers. The existence of paranoia as a special form of insanity is vigorously combated by the author, while such other special forms as katatonia, confusional and stuporous insanity are not even mentioned. We are glad to note that the author advocates the treatment of some cases of insanity outside of the asylum.

Some eighty pages at the end of the book are devoted to extracts from the laws of the different States and Territories of the United States which relate to the general care of the insane. Unfortunately, these are, in some instances, not given at sufficient length to be of much value.

Taken all in all, the book is of such a character that it would enable a student or general practitioner to obtain a good working knowledge of insanity and would supply him a safe guide for treatment. The specialist will find nothing new in it save the notes of the author's experience at the Hartford Retreat, of which some of the cases recorded constitute a real contribution to the science of psychiatry.

THE ANATOMY OF THE PERITONEUM. By FRANKLIN DEXTER, M.D., Assistant Demonstrator of Anatomy, College of Physicians and Surgeons, New York. 12mo, pp. 86, with 38 illustrations. D. Appleton & Co., 1892.

THIS is a valuable contribution, intended to render more clear that unsatisfactory and incomprehensible anatomic part, the peritoneum.

The author, taking the description of Prof. Toldt, of Vienna, of the development of the peritoneum, as a basis, has enlarged the work with many plates, and has so planned it that the student is taken along, step by step, in the most elementary manner, with comparative ease, to a perfect understanding of the subject. It is not sought to impress the embryologic details, but their results. The study of the development of the organs not only contributes valuable information as to their normal position, but renders the knowledge of abnormalities more comprehensible. Thus, the hiding from view of a portion of the duodenum by the mesentery of the transverse colon, the absence of peritoneum on the posterior surface of the mesentery and a portion of the colon, the high position of the cecum in children in relation to the liver rather than to the iliac fossa, the simultaneous development of the peritoneum and the intestine (that the intestine has not, after it has been formed, been pushed into the membrane as a finger into a glove), and many other points are satisfactorily explained.

The work is of a highly scientific character and of considerable practical value, and the author is to be highly commended for the production of a work which reflects great credit upon his ability as a practical scientific anatomist.

PHYSIOLOGY. A MANUAL FOR STUDENTS AND PRACTITIONERS. By FREDERICK A. MANNING, M.D. (The Students' Quiz Series.) Philadelphia: Lea Brothers & Co.

THIS little book claims to be but a brief summary of the salient features of human physiology. This is the statement with which the writer begins his preface, and it requires but slight acquaintance with the book to prove that he appreciates the proper sphere of the quiz compend. The terse answers to questions, and the descriptions which he gives, while they contain the pith of the subject, could not be made to take the place of the study of one of the standard text-books; but once the information is acquired from such a source, this manual will be an excellent help to fix it in the mind of the student preparing for his examination, or, perhaps, to refresh the memory in after years.

On looking through the various sections of the book—on the Blood, the Circulation, the Respiration, Digestion, Absorption, Animal Heat, Secretion, Muscle, Nutrition, the Nervous System, the Senses, and Embryology—we confess to be well pleased with it, as a whole. Of course, everything is much condensed, as it is proper that it should be, but the author has succeeded very well in presenting the essence of the subject. In an appendix are given a Table of the Development of the Embryo, a list of the Chemical Tests used commonly in Physiological Analysis, and the Metric System, which are well to have at hand.

Dr. Manning has based his book mainly on the works of Dalton, Foster, and Kirke. He has written in a very readable style, and deserves to be congratulated on his contribution to the Quiz Series.

TRANSACTIONS OF THE AMERICAN GYNECOLOGICAL SOCIETY. Vol. xvii, 1892. Philadelphia: William J. Dornan, 1893.

THIS volume presents in the usual complete form several interesting contributions, among which are to be noticed particularly the extensive paper upon "Tuberculosis of the Female Generative Organs," by J. Whitridge Williams, of Baltimore, Md. This article is very extensive in its scope and presents a complete history of the investigations in this field of Gynecology. The writer naturally devotes most of his space to the consideration of tuberculosis of the tubes, as these are the primary seat of tuberculous infection, of the genitals as well as the organs most extensively affected. The frequently observed fact of the limitation within the internal os of tuberculous endometritis is forcibly noted. Another paper of interest is that of Dr. Edward Reynolds, of Boston, on "The Value of the Forceps in Complicated High Arrest of the Breech, with Report of Two Cases." The description of the adjustment of the blades to the breech is unusually instructive, inasmuch as the

safe application, in which the lower part of the breech is grasped, and that by the tips alone, will enable future operators to appreciate the proper application, whereas otherwise the instrument might be introduced too far, in the mistaken idea that a high application is the desideratum.

In addition to these papers that of the President, Dr. Byrne, of Brooklyn, upon the conservative versus the radical treatment of "Carcinoma of the Uterus," is important.

TABLETS FOR THE MEASUREMENT AND RECORDING OF THE MAGNIFIED IMAGE OF THE FUNDUS OF THE EYE. By DR. FLAVEL B. TIFFANY, of Kansas City, Mo. Published by Osborne & Pitrat, Kansas City, Mo.

THE author of these ingenious tablets has taken advantage of the well-known fact that the enlargement of the upright image in ophthalmoscopy depends upon the distance to which the image is mentally projected. Assuming, therefore, that the magnification of twenty times—about the ordinary amount of enlargement in the upright image—necessitates a chart of such dimensions to be placed thirty centimeters back of the observed eye, the observer is at once given a graduated blank by which the details of any fundus oculi, in almost the exact size of those seen in the ophthalmoscopic picture, can be projected on a sheet by his unused eye.

We have successfully taken advantage of the method in a number of cases, though we find by comparison with others that it does not adapt itself to those observers who are presbyopic and not ambidextrous.

THE DISEASES OF CHILDREN, MEDICAL AND SURGICAL. By HENRY ASHBY, M.D. Lond., F.R.C.P., and G. A. WRIGHT, B.A., M.B. Oxon., F.R.C.S. Eng. Second edition. Edited for American Students by WM. PERRY NORTHRUP, A.M., M.D. 8vo, pp. 773. New York and London: Longmans, Green & Co., 1893.

THE additions and comments of the American editor have not been included in the text, but are collated in the appendix with proper reference. The formulæ have been rewritten to conform with the U. S. P. The work itself has, by its passing to a second edition, been stamped with professional approval; and it is, indeed, an accurate and reliable guide to the diagnosis and treatment of the diseases studied. We note with pleasure the acknowledgment made by the authors to successive generations of house-surgeons whose well-kept notes of cases have been utilized. Few American authors can make similar acknowledgment. The style of the authors is easy, but clear; and while it is concise, no important fact has been sacrificed to condensation. We can cordially commend it to student and practitioner.

CORRESPONDENCE.

FRACTURE OF THE HUMERUS DURING DELIVERY.

To the Editor of THE MEDICAL NEWS,

SIR: I see reported in THE NEWS several cases of fracture of the femur during delivery. Allow me to report a case that occurred to me a good many years ago, and has never been reported.

I was engaged to attend Mrs. ——, a primipara, the wife of a mill-owner, a very stingy fellow. When labor commenced he sent for a "wise woman," who, he was told, knew more about such cases than any doctor, in order that he might save a part of (in those early days) my small fee. About daylight one morning he came for me at a hard gallop, saying that his wife was bleeding to death. I went at once, and found a rather severe case of post-partum hemorrhage, and a roomful of awfully frightened women, the "wise woman" as white as Hamlet's ghost, for her patient was in a dead faint. Happily the patient responded to stimulants, and I succeeded in arresting the hemorrhage.

The nurse then said to me: "Doctor, there is something wrong with the baby's arm." On examination I found a simple fracture of the humerus, between the upper and the middle third. I could not learn the presentation. I reduced the fracture, and put it up in a moulded pasteboard splint. Union took place in a short time, and there was no deformity.

I had the satisfaction of charging and collecting full fees in both cases. *I also introduced the next baby.*

Respectfully, N. AGNEW, M.D.

WINNIPEG, MANITOBA, CANADA.

SOCIETY PROCEEDINGS.

AMERICAN MEDICAL ASSOCIATION.

Forty-fourth Annual Meeting, held at Milwaukee, Wis., June 6, 7, 8, and 9, 1893.

(Continued from page 677.)

SECTION OF DISEASES OF CHILDREN.

FIRST DAY—JUNE 6TH.

DR. CHARLES G. JENNINGS, of Detroit, delivered the President's Address, which was entitled "Some Recent Advances in Pediatrics." After thanking the Section for the honor conferred upon him, the Chairman called attention to the recent changes in the organization of the Association that give to the Section work, and to the scientific work their proper position as leading factors in the organization. He pointed out that the Section has heretofore lacked cohesion and coöperation. The membership of an undifferentiated section is diffuse and unstable, and it cannot exert the influence in the Association and the profession that it should. Pediatrics covers almost the whole field of medical and surgical specialties. Including in its membership general practitioners and specialists, the Section is most favorably organized to carry out its function of collecting and disseminating the most advanced teachings in this department of medicine. The Chairman urged the necessity of more firmly establishing the Section's autonomy. He advised the cultivation of a more intimate social relation among the members, full and prompt reports of discussions and proceedings, and the arrangement by the officers of the section of short, practical papers, in series, on live subjects. The Chairman then briefly reviewed some of the recent advances in pediatrics. He called attention to the more extensive use of the bath in febrile diseases, and noted that the bath frequently, and properly, re-

placed active antipyretic drugs. Considerable attention was devoted to a review of the recent investigations into the etiology of diphtheria and the relation that the disease bears to the various pseudo-membranous throat-affections.

The difficulty was emphasized of accurately diagnosticating diphtheria from similar conditions by clinical means alone, and the necessity of bacteriologic examinations was urged. In cases of doubt, and when these examinations cannot be made, the doctrine of isolation should be observed to its farthest limits.

DR. W. A. DIXON, of Ripley, Ohio, read a paper entitled "Observations on Isolated Cases of Diphtheria." He stated diphtheria is a common and destructive disease, from which rich and poor alike suffer severely. Sanitary conditions seem to have little to do with its prevalence. It has always displayed a marked tendency to prevail in sparsely populated districts rather than in centers of population. In the United States it occurs as often on the hilltop as in the crowded city tenement houses. Pathologic reports are replete with statistics showing the communicability of diphtheria from the lower animals to man.

Cases of isolated diphtheria were cited to show that children have been infected from birds, fowls, pigeons, and cats. In 1865 an epidemic of malignant and fatal diphtheria prevailed in Southern Ohio following a period of great fatality among the hogs and chickens of that region.

In another case, a child, whose home was perfectly isolated, and who had a pet cat which it nursed continually, and which had been ill some days and had a discharge from the nostrils, was seized with diphtheria.

DR. G. BENSON DUNMIRE, of Philadelphia, read a paper entitled "Some Observations in Treating Cases of Diphtheria."

DR. F. E. WAXHAM, of Chicago, presented the following table of statistics of intubation:

Age.	Cases.	Recoveries.	Percentage.
Under 1 year	13	4	30.76
1 "	62	13	20.96
2 years	81	25	30.86
3 "	85	32	37.64
4 "	90	35	38.88
5 "	43	19	44.18
6 "	26	7	26.92
7 "	29	10	33.33
8 "	13	8	61.53
9 "	7	3	42.85
10 "	7	3	42.85
11 "	1	1	100.00
12 "	3	0	00 00
13 "	1	0	00.00
14 "	1	0	00.00
20 "	1	0	00.00
36 "	1	0	00.00
43 "	1	1	100.00
60 "	1	0	00.00
	466	161	34.54

DR. WAXHAM also read a paper entitled "The Therapeutics of Diphtheria." He expressed the hope that the inoculation-treatment of diphtheria will soon replace all other methods of treatment. There are still great difficulties to overcome, however, before the method can be applied to man. The treatment of diphtheria may be considered under the following four heads: (1) Nourishment, (2) Stimulation, (3) Internal Medication, (4) Local Antisepsis. The importance of feeding is often overlooked, especially as to the amount that is taken. On account of loss of appetite, the patient may refuse all kinds of food. In such a case, peptonized food by enema or by the stomach-tube may be resorted to. Mild cases do not demand the use of alcoholic stimulants, but severe cases do demand them. When required, alcohol should be given freely at least one or two teaspoonfuls every hour, or half-hour, according to the urgency of the case. If necessary, strychnine, musk, or ammonia should be given. The tincture of ferric chlorid is a valuable agent. It should be given in frequent and full doses—ten, fifteen, or twenty drops to young children and should be repeated every hour or half-hour. Mercuric chlorid or potassium chlorate may be given, but in severe cases of diphtheria either is too irritating to the kidneys. The local antiseptic treatment is of great importance. Carbolic acid, mercuric chlorid, tannic acid, chlorin water, or hydrogen dioxid may be used. The results, however, will not depend so much upon the remedy employed as upon the method of employment. In the strength of 1 to 4000 mercuric chlorid is not irritating. Hydrogen dioxid, 1 to 4, is not irritating. The spray is to be preferred to the douche. One of the most efficient means of flushing the nasal cavities is by the use of the soft catheter. The indications in the treatment of diphtheria are to destroy the bacilli and to support the system by abundant nourishment, free stimulation, and full and frequent doses of iron.

DR. J. A. LARRABEE, of Louisville, stated that it is always well to give the patient the benefit of any doubt and treat the case from the first as though it were one of diphtheria. There are some points by which the diagnosis can often be made rather early. The constitutional disturbances of tonsillitis are sometimes profound, but they are not associated with the blood-changes observed in diphtheria. Albuminuria is present in almost all cases of diphtheria in the second stage. Glandular enlargements are also present in diphtheria. The appearance of the pseudo-membrane cannot be relied upon. In the preventive treatment tincture of ferric chlorid is to be preferred, which should also be given during the whole course of the disease. It is usually not given in large enough doses. It increases the number of red blood-corpuscles, and thus renders it possible for a larger amount of oxygen to be taken into the body. It also stimulates the appetite and acts as a diuretic. Local treatment should precede or at least accompany the constitutional treatment. Mercuric chlorid is objectionable. If used as a gargle or spray death may result. Hydrogen dioxid, used carefully, does well. Too strong solutions may cause sloughing. As it is almost impossible to spray or irrigate the child's throat the insufflation of boric acid and pepsin or papain is to be preferred. Argentic nitrate is also entitled to consideration. As one attack of diphtheria does not confer immunity to subsequent attack, the value of treatment by inoculation is doubtful.

DR. DOUGLASS, of Detroit, stated that if the tonsils are much inflamed and swollen and encroach upon the air-passages, it is well to incise them. He has not observed this operation to be followed by septic poisoning.

SECOND DAY—JUNE 7TH.

DR. W. S. CHRISTOPHER, of Chicago, read a paper on "The Pathogenesis of Bronchitis." It was shown that bronchitis arises from a large variety of causes. This multiplicity of cause indicates that the disease is probably always secondary and never primary. The principal causes are the poisons of acute infectious diseases, intestinal infection, malnutrition, and bronchoadenitis.

DR. C. L. DODGE, of Kingston, N. Y., read a paper on "The Pathology and Symptomatology of Acute Bronchitis and Broncho-pneumonia." The pathology of acute bronchitis was stated to be "an inflammation affecting a mucous structure, leading to a secretion of mucus and the production of muco-pus in greater or less abundance." The symptoms differ much in degree and as the disease is mild or severe. In addition to the usual premonitory symptoms of coryza, etc., there is a harsh paroxysmal cough. The respiration is accelerated, and in mild cases there is slight fever. In severe cases the fever is considerable and the pulse frequent. The temperature ranges from 101° to 102° F. In severe cases it may reach 103° F. The skin is dry and hot and the cheeks flushed. The cough in many cases is harsh, dry, and persistent. There is also more or less laryngitis, together with pharyngitis of mild grade.

Catarrhal pneumonia is not, like croupous pneumonia, a distinct and independent disease clinically, but in the great majority of cases it is a secondary phenomenon in the course of acute and chronic diseases of various kinds. It almost always follows bronchitis. The same process that causes catarrh of the bronchial mucous membrane, in its further course, invades the bronchioles and alveoli and leads to catarrhal pneumonia.

Broncho-pneumonia is usually preceded by acute bronchitis. The extension of the disease to the lung-tissue proper manifests itself by dyspnea, a change in the character of the cough, and the purulent character of the sputum. When extensive collapse takes place the dyspnea increases, the temperature falls, the cough ceases, and the child rapidly sinks into a comatose condition. The pulse is extremely rapid and runs from 150 to 200. The respiration is also increased, and in severe cases reaches 80 per minute. The temperature will average 104° or 105° F. in acute cases. There is no regular ratio between pulse, temperature, and respiration. Anorexia and thirst are prominent symptoms. On auscultation during the early stages râles of all sorts and sizes may be heard, but it is at a later period that there are persistent subcrepitant râles in one or more spots.

DR. J. M. G. CARTER, of Waukegan, Ill., read a paper on "Some Phases of Broncho-pneumonia in Children." Attention was directed to a class of cases that do not receive the careful observation that they merit. Common colds in children frequently develop into severe attacks of broncho-pneumonia. Many cases recover spontaneously, so that the number of cases that come under the observation of physicians is diminished, and the rate of mortality ascribed to broncho-pneumonia appears high. A recurrence of broncho-pneumonia from colds in adolescence and middle life may develop fibroid pneumonitis. In old people and in children under five years of age, broncho-pneumonia causes the greatest mortality. In simple cases, the chest should be enveloped in cotton batting, the patient kept quiet in bed, and mild anodyne expectorants administered.

DR. F. S. CHURCHILL, of Chicago, read a paper on "The Pathology and Symptomatology of Croupous Pneumonia." Croupous pneumonia in the child, as in the adult, was defined as an acute, infectious, self-limited disease, having its chief pathologic manifestations in the lungs. The pneumonic lung of the child is not as greatly distended nor as solid as that of the adult. It is denser and darker-colored than normal. The surface is rather smooth, and the inflammatory exudation less marked than in the adult. It is not uncommon to find abscesses near the surface following the third stage.

The microscopic appearances are much the same as in the adult. The exudate is usually fibrinous, and contains numerous red and white blood-corpuscles. When it begins to liquefy it contains diplococci, which closely resemble the pneumonia-microbes. The morbid process has a strong tendency to affect the lower lobe; more frequently on the right than on the left side. The onset is usually sudden, with stabbing pain in the side, suppressed cough and rusty sputum; but in children this complex of symptoms is not always present, and the diagnosis is often difficult. The child usually complains of pain in the epigastrium, and headache, accompanied by rise of temperature. The child is usually found breathing rapidly with an "expiratory grunt," its face flushed, the alæ nasi dilated, and the expression painful. The affected side may be noticed to lag. Vocal fremitus may be increased. The respiratory murmur may be bronchial. Râles are rarely heard in children less than three years old. On percussion, a sense of resistance is appreciated over the affected area. Cerebral symptoms vary in intensity, from restlessness to severe convulsions. A certain degree of cyanosis may be present. The temperature varies from 102° to 106°. The pulse and respiration are frequent. The proportion of cases ending by crisis is greater than in adults.

DR. I. N. LOVE, of St. Louis, read a paper entitled "The Therapeutics of Bronchitis." He stated that some observers maintain that bronchitis is due to a special germ, whose port of entry is the air-passages, but the majority admit, however, that bronchitis is, as a rule, simply a result of "taking cold." The predisposing conditions are constipation, improper diet, disturbed digestion, perverted secretions, and exposure to cold. In the therapeutics of bronchitis, the general torpor of the glandular apparatus must not be ignored. The bowels should be thoroughly moved by means of calomel or a saline, followed, if necessary, by castor oil. These remedies mentioned, together with turpentine, serve to stimulate the secretory activity of the mucous glands of the air-passages, and favor expectoration. Local applications may be made to the chest. If the temperature is high, some one of the antipyretics should be given in a stimulating menstruum to reduce the temperature to proper limits. Too high a temperature is dangerous, no matter what the affection may be. It is to be borne in mind that bronchitis in children may terminate in catarrhal pneumonia. Stimulation at the proper time is important, and it is often of advantage to give one or two teaspoonfuls of equal parts of whiskey, glycerin,

honey, and some preparation of malt. The secretions should be stimulated and rest secured. Dover's powder may be used to advantage. Malaria should never be overlooked, for it is remarkable how often it is a potent factor in a case of bronchitis in a child. After the acute stage has passed, turpentine, or terpin hydrate can be given, together with mild tonics and a nutritious diet. Special emphasis is to be laid upon elimination, tranquillization, stimulation, nutrition, and oxygenation.

DR. F. S. PARSONS, of Northampton, Mass., read a paper on "The Therapeutics of Broncho-pneumonia." He stated that a comfortable, well-ventilated room is essential to successful treatment. Exposure is to be prevented, if possible. The patient should be clad in soft flannel and kept in bed. It is well to direct a chest-protector to be worn. This is preferable to poultices, ointments, and other applications. If the case is seen early, medication is to be directed to the cough and to the promotion of resolution, but if seen late and the child is weak, stimulation must be resorted to, for which brandy is to be preferred. Digitalis in drop-doses is valuable. If the temperature is high acetanilid or aconite may be used; the latter being preferable in very young children. It may be necessary to administer an emetic to free the stomach and bronchial tubes. Under such conditions small doses of calomel may be administered to empty the stomach and intestines. The position of the child's body should be changed frequently, to prevent hypostatic congestion. If there is a tightness of the chest, the boiling of water in the room will frequently do good. To stimulate the action of the mucous glands and to increase the watery elements of the secretion the spray is indicated, and the best drug is ipecac in some form. Opium may be combined with ipecac to relieve irritability. As a diuretic, potassium citrate is to be recommended. Ammonium and other stimulating expectorants are useful in the later stages. During convalescence tonics of iron and a good nutritious diet are always useful.

DR. J. A. LARABEE, of Louisville, read a paper on "The Therapeutics of Croupous Pneumonia." He recommended a formula containing spirit of nitrous ether, f℥jss; potassium acetate, ℥jss; solution of ammonium acetate, water, and camphor, each, f℥iij. The solution should be slightly acid in reaction. The dose for an adult is one tablespoonful; for a child a teaspoonful, every two hours. To this may be added aconite or veratrum viride, and during convalescence tincture of ferric chlorid.

Death usually occurs through the heart. *Pari passu*, with the consolidation of the lung, and in direct proportion to its extent, the transfer of blood from the right to the left heart is mechanically obstructed. The condition would be rendered still more dangerous by the use of such a stimulant as digitalis. The ligation of the lower extremities, sufficiently to prevent return of venous blood, relieves the heart. The application of dry cups and flaxseed poultices to the chest is of service. The best results are to be obtained, without jeopardizing the life of the patient, and without interfering with convalescence: (1) By agents that determine the blood to the skin; (2) by belladonna; (3) by nitro-glycerin and the nitrites; (4) by applications to the chest.

The mixtures usually prescribed for the cough of pneumonia contain ipecac and squills to loosen, senega and ammonium to stimulate, wild cherry and other tannates to check secretion; alkalies to lessen the viscidity of the mucus; and opium to dull sensibility. Water given in abundance and at short intervals is the best and only expectorant required. Purgatives add to the general depression. If the bowels need attention, they should be moved by simple enemata.

Hyperpyrexia usually yields to the warm bath or pack. The pack is preferable to the bath.

DR. JAMES B. HERRICK, of Chicago, stated that in cases of central pneumonia the physical signs are frequently so imperfectly marked that the diagnosis is very uncertain. The pain is so frequently referred to the epigastrium that attention is attracted to this region, but the rapidity of the respiration should direct attention to the chest. The broncho-pneumonia that occurs in the new-born is probably due to the inhalation of liquor amnii.

DR. E. E. GRAHAM, of Philadelphia, stated that if, in the treatment of pyrexia, he were limited to a single agency, he would not hesitate to accept cold as the best. If cold is applied at all, it should be done fearlessly. Depressing effects do not follow the proper employment of cold. Good results may also be obtained from cold water injections; from a pint to a pint and a half can be injected at a time. Aconite should be used with the greatest caution.

DR. CHARLES G. JENNINGS, of Detroit, stated that the bath is a stimulant to both respiration and circulation, as well as a good antipyretic. Drugs may be used in the beginning of the disease; but during the latter part of its course the bath, beginning at 90° and gradually reduced to 80° or 75°, acts as a stimulant to all of the functions and will reduce the temperature to a safe point.

DR. J. M. G. CARTER, of Waukegan, Ill., stated that, according to statistics, there are 561 deaths per million due to bronchial affections in the city, to 165 per million in the country. Among the Indians there are only 10 deaths per thousand attributable to bronchitis, while among the whites there are about 28 per thousand. These figures go to show that exposure does not play a very important rolê in its causation.

THIRD DAY—JUNE 8TH.

DR. J. A. WORK, of Elkhart, Ind., read a paper on "The Importance of Early Effective Elimination in the Zymotic Diseases of Children." All children equally exposed to a certain contagion do not alike contract disease. Because some are in a healthy condition, the system is in a normal physiologic condition, the poison finds no nidus of effete matter or no lodgment to encourage it to remain.

A system thoroughly cleansed of all effete and residual matter is rendered less susceptible to, if not entirely exempt from, the poison of scarlatina. It is, therefore, a rational procedure, in treating little patients, to eliminate as early as possible through all channels and maintain the normal action of the eliminative organs throughout the entire course of the disease.

Early elimination is important in all zymotic diseases, and, if practised early, will in many cases prove abortive.

DR. MARION THRASHER, of San Francisco, read a paper on "Dentition and Some of its Diseases." It was

pointed out that normal dentition is comparatively harmless, but in this age of civilized refinement abnormal dentition is the rule, and the danger is constantly increasing. A few decades ago, when it was more general than now the practice of mothers to nurse their children, the fatality was not nearly so great.

Dentition in artifically-fed children develops incidentally many diseases. The commonest are irritative fever, indigestion, convulsions, stomatitis, capillary bronchitis, and pneumonia.

Purulent conjunctivitis may arise when the upper canine teeth are being cut, the inflammation being transmitted through the antrum of Highmore. Cough is often present when the upper teeth are being cut. Eczema impetiginosum may also occur at this period. During the evolution of the teeth the submaxillary glands are often swollen and the cervical glands may enlarge and suppurate, especially in scrofulous or rachitic children.

The hygienic and dietetic conditions should be made most propitious. The diarrhea that is often present is usually best met with minute doses of hydrargyrum cum creta, sodium bicarbonate, and tannin, for a day or two, followed by oil. Excessive temperature should be controlled. Cutaneous affections require no special attention during this period. Diseases of the respiratory organs should receive attention. Restlessness should be overcome by hot baths, aconite and bromids.

Delayed dentition in puny children may be remedied by vigorous constitutional treatment, including pure air, proper food, bathing, ferric citrate, cod liver oil, quinine.

DR. A. FOSTER, of Chicago, laid stress upon the importance of discriminating between the effects of teething and those of improper feeding. He also pointed out that there may be a reflex relation between the cutting of teeth and the stomach, as well as there is between the uterus and the stomach, and that all of the trouble arising during dentition may not be due to the stomach alone.

DR. J. WELLINGTON BYERS, of Charlotte, N. C., read a paper entitled "Phenomena and Causes of Gastro-intestinal Fever (not typhoid.") He said that there is a large class of gastro-intestinal disorders characterized by phenomena closely resembling those of typhoid fever, which deserve special attention and study from the fact that they are often confounded with the latter condition, and a line of treatment is instituted that serves only to aggravate and protract them. These disorders have been variously designated as gastric fever, gastro-intestinal fever, pseudo-typhoid, abortive typhoid fever, simple fever, and continued fever, though they are all phases or forms of the same disease, namely, disordered digestive processes leading to putrefactive changes in the alimentary canal, and the absoption of toxins into the circulation. They set in with a diversity of symptoms, in accordance with the individual attacked and the specific etiologic agents. They are most frequently traceable to errors of diet; but fatigue, anxiety, shock, undue physical and mental exertion, exposure to a foul, damp atmosphere, and the heat of the sun may act as causes. As a rule, young children and those with feeble digestive powers are most susceptible. The attack sets in with a feeling of indisposition, followed by chilliness, fever, headache, thirst, anorexia, and pain in the back, abdomen, and limbs. The tongue is coated with a white fur, and the pulse is accelerated. There is commonly constipation, though in young children diarrhea is often present. The pyrexia reaches its maximum early on the first or second day. The duration of the attack is usually less than a week if proper treatment be instituted; otherwise, the disease may continue for an indefinite time, and thus simulate typhoid fever. As contrasted with the latter, the rise of temperature is sudden, the highest, 104°, being reached in the first few days of the invasion. The bowels are most frequently constipated; there is absence of the characteristic typhoid tongue; and there is no circumscribed iliac tenderness or tympanites, but a general soreness over the entire abdominal region. The prostration of the nervous system is not so marked as in typhoid, though patients often complain of great muscular weakness even after a few days' illness. In an etiologic connection recent developments in physiologic chemistry and bacteriology have shown that whenever from any cause the normal digestive functions are perverted, putrefactive processes occur in the alimentary canal. Disordered innervation, originating under debilitating circumstances of environment, acts as a predisposing cause by leading to perverted glandular and cellular function, thereby facilitating the production and absorption of alkaloidal poisons from the digestive tract. The old notion that a torpid liver is conducive to putrefactive changes in the intestines is the correct one. The hepatic condition is frequently the first recognizable stage in the causation of the disorders enumerated, and the first step in all treatment for their alleviation should be directed toward the restoration and maintenance of the hepatic functions. The first element of success is the differentiation from typhoid conditions. This being done, food should be withheld until the putrefactive substances have all been removed from the canal, and then a line of medication should be instituted that will tend to restore normal cell-function by promoting the trophic forces and the anabolic processes.

DR. J. SCHENCK, of Mt. Carmel, Ill., read a paper entitled "Cholera Infantum; Its Treatment in Malarial Localities." He defined cholera infantum as a disease of early childhood, in which there is exalted excitability of the nerve-centers and of their meninges, producing high fever and causing sudden attacks of forced vomiting and violent purging, which, if not controlled, result in exhaustion and death in a short space of time. The primary cause is continuous, high summer heat, both night and day, combined with malarial or other miasmatic poisoning. The secondary causes are indigestion and fermentation of the food-contents of the alimentary canal, including decomposition of the normal secretions and excretions of the digestive tract.

The preventive treatment is mental and physical quiet. The body should be kept as cool as possible during the time of greatest heat; pure and easily assimilable foods should be given; all unhygienic conditions should be removed; digestion should be aided by pepsin; malarial influences counteracted by quinine, and nervous excitement by physostigma venenosum.

For curative purposes, the little patient should be placed on a rubber bag filled with cold water; exalted nervous action should be inhibited with sodium bromid and physostigma, repeated until their physiologic effects

are produced, or, in older children, hypodermatic injections of morphin may be given to accomplish the same object; cold egg-water should be given to allay thirst and fever; small doses of morphine and carbolic acid to control vomiting, and large mustard plasters should be applied to the extremities to relieve central congestion; the secretions and excretions should be stimulated by means of small doses of calomel and sodium bicarbonate. After reaction has taken place, the case is to be treated as one of severe entero-colitis—a condition that is almost certain to follow.

DR. M. G. SLOAN, of Dexter, Ia., read a paper entitled "Meningocele, with Case." The occurrence of pure meningocele is doubted by many, and is certainly very rare. The diagnosis is difficult. The condition is often diagnosticated as hydro-cephalocele. With modern antiseptic methods the operation for removal should be a comparatively safe one. In the case reported and operated upon the result was a perfect cure. Not a vestige of anything resembling brain-tissue was found.

DR. THOS. H. MANLEY, New York City, read a paper entitled "The Etiology, Morbid Anatomy, Diagnosis, and Treatment of Infantile Hernia of the Inguinal Type in the Male." It was maintained that the predominating elements in infantile hernia are anatomic, but heredity also plays an important rôle. The mal-descent of the testis is more often responsible than all the other known causes combined. The causes being so variable, the treatment also must be variable. The diagnosis of the inguinal type of infantile hernia is not difficult in the majority of cases, but in many forms of cystic disease of the cord an accurate diagnosis is not always possible.

The treatment will include attention to diet, clothing, rest, support or pressure, removal of such causes as occasion straining, and radical operation.

DR. WILLIAM E. WIRT, of Cleveland, Ohio, read a paper entitled "Hernia in Children." He spoke of the frequency and varieties of hernia in children. The condition is much more common in males than in females. Umbilical and femoral hernia are much more frequent in females than in males, but femoral hernia is rare in children. As etiologic factors, climate and the condition of the patient were mentioned. The treatment was considered under three heads, viz.: 1. General treatment; 2. Mechanical support; 3. Operative measures.

A paper entitled "Acute Endocarditis of Children; Etiology, Symptomatology, and Treatment," by C. N. HIGHLEY, of Conshohocken, Pa., and one entitled "Primary Syphilis and Gonorrhea in Children," by B. M. RICKETTS, Cincinnati, Ohio, were read by title.

(To be continued.)

AMERICAN ACADEMY OF MEDICINE.

Eighteenth Annual Meeting, held at Milwaukee, Wis., June 3 and 5, 1893.

(Continued from page 680.)

SECOND DAY—JUNE 5TH.

DR. BENJAMIN LEE, of Philadelphia, presented a paper entitled "The Duty of the State to Medicine." He urged that the State should recognize that it incurs obligations at the same time that it imposes obligations upon the medical profession. Among these are the duty of according to physicians occupying official positions equal recognition, rights, privileges, ranks, and emoluments with others, notably the legal and military professions; of securing to the medical profession such a standard of education and attainments as shall enable it to command the respect due it; of paying for services demanded; of protecting its members against malicious prosecutions; of officially recognizing achievements in medicine and surgery, and, finally, of recognizing the importance of State medicine. "The health of the people is the first duty of the statesman."

DR. GASTON said that the public should be compelled to recognize its obligations to the profession by statutory enactments, if necessary. The public seems more ready to recognize the quack than the educated physician. Medical officers should be empowered to perform their duties without secondary orders from superior officers. The necessity of preliminary training was emphasized. Dr. Gaston deplored the tendency in the South to neglect such training. Without preliminary education the student cannot understand medical lectures, and part of this training should be under preceptors and in active office-work. The necessity of the business aspect of the physician's life was urged as an element of success. The State should be required to pay for all medical services demanded. Pay for expert testimony by the courts is at present a farce. The profession should have a cabinet officer. If the profession would work together, this could be brought about. The organization of State Medical Examining Boards is a wise choice of evils. School diplomas cannot be relied upon. In malpractice suits the innocent should not be allowed to suffer. Rashness and ignorance should be punished.

DR. MARCY called attention to the fact that by the proposed extension the work of the Academy would be enlarged. The physician is not only a doctor; he is also a man and a citizen. The coroner system, for example, is a blot and a disgrace to our civilization.

DR. CONNOR said that if every physician taught his patients and friends their duties, there would be no trouble. The teachers do not stand together. Most malpractice suits originate with some member of the profession. The profession should be the teacher.

DR. HOLMES alluded to the injustice of hospitals not paying physicians, as every other attendant—nurse, superintendent, etc.—is paid. The remuneration of the physician may consist in permission to utilize clinical material for clinical instruction. The reimbursement would come back to the public. It is an axiom, or should be, that no gratuitous service can be *demanded* of a physician. If he does give it, it is given as a delegate from the profession.

DR. C. C. BOMBAUGH, of Baltimore, read an excellent paper entitled "Literary Recreations of the Physician." Among other things, he said that there must be some form of recreation to compensate for the trials and anxieties of the physician, and among the methods of relaxation one is in weaving from his own unfettered fancies story or song, poem or play, essay or critique, brochure or quarto. *The Index-Catalogue of the Surgeon-General's Office* shows what medical men have done for medical literature. While they have not been so prolific in general literature, they have contributed much that commands widespread admiration. A great deal of this, it

is true, has been written by those who have withdrawn from active practice, hence Copernicus, Galileo, Servetus, and others of their class are not thought of at the first as physicians.

Others have found themselves not able to bear the wear and tear of active practice. Among these may be found Schiller, Thomas Huxley, William Farr, Erasmus Darwin, and Charles Lever. Others, like Abraham Cowley, never attempted to practise, but still others mingled their literary pursuits with an active practice. Mark Akenside, Dr. Arbuthnot in the reign of Queen Anne, Sir Richard Mead, who was physician in ordinary to George II, were mentioned among others.

America has quite a respectable list of such men, from Benjamin Rush, David Ramsay, Samuel Hopkins, and others of the Revolutionary period, to authors of the present day. Literary occupation is not work, however, in the ordinary sense of work; it is diversion, the safety-valve for weariness. Thus the Autocrat of the Breakfast Table has shown how the Anatomist in the Lecture-room could trace the tortuous windings of the trigeminus, and then go home and pen such immortal verse as the "Living Temple" or "The Chambered Nautilus." Fair characterization has not yet been accorded the physician by the modern novelist. The satire of the earlier writers has castigated the pretenders of the past, but the qualities and qualifications of the end-of-the-century physician, whose education ends only with his life, who meets conscientiously all moral and legal responsibilities, or who is ever ready for self-renunciation and self-sacrifice, have not been fairly weighed and measured by the end-of-the-century literary class.

Rudolph Virchow, who has not only reached the top of the ladder as a biologist and a pathologist, but has also climbed high as a statesman and a politico-economist, recently remarked that, "after wearying, useless efforts in political, social, or religious matters, scientific work is a recreation."

DR. J. CHESTON MORRIS, of Philadelphia, presented a communication entitled "The Care of Abandoned Infants." He said that in Roman times the infant born in the house was brought to the head of the house, to be acknowledged and taken care of or to be refused and slain.

In medieval times, children abandoned by their parents were exposed in front of the church, for adoption. Gradually the foundling asylum took the place of this cruder method, until the horrible results in the way of infant-mortality and of incentive to criminal life caused the system to be abolished in France and Belgium.

In the United States the almshouse afforded a refuge not much better than the foundling asylum abroad, and few infants survived the troubles and diseases of infancy.

In consequence of the publicity given to the facts some ten or twelve years ago, an institution called "Sheltering Arms" was established in Philadelphia, on the principle of trying to save the mother through the love for her offspring. The results have been most satisfactory and encouraging. No infant is refused, but the effort is always made to find and keep together mother and child. After several months of residence in the house, where the mothers do the most of the work, a place is found in the country for her, and the effort is made to keep in touch with her by correspondence.

No woman is destitute wholly of the true maternal instinct. It may be clouded or overshadowed, and if she is permitted to make away with her child, or even to abandon it, her moral nature receives a wound difficult to heal and always leaving a horrible scar.

DR. C. MCINTIRE, of Easton, Pa., read a paper entitled "The Importance of the Study of Medical Sociology." He quoted from the *Century* dictionary the definition of "sociology" as: "The science of social phenomena; the science which investigates the laws regulating human society; the science which treats of the general structure of society, the laws of its development, the progress of civilization, and all that relates to society."

Is there a special department of medical sociology? Are physicians peculiar, because physicians? If this view is taken, reference may be made to the past and present discussions on the codes of ethics. But there is the other view—the relation of the physician, as a physician, to the world about him. Medical sociology has, then, a twofold aspect—the social science of physicians regarded as a class, and the peculiar relations that the practice of medicine may bear to the social structure as a whole.

Does the physician differ from his fellow-men engaged in other pursuits? There is a language peculiar to the physician; there are customs peculiar to him. Other characteristics are a tendency to undue specialism and an incongruous admixture of conservatism and credulity. The relation of the physician to society at large is shown by his efforts to relieve suffering among the "under half"; in the results of his labor in sanitary science as a factor in the solution of municipal questions, the construction of dwellings; in the care of armies and of fleets; in the true presentation of the desirability of physical education. The classification suggested for sociology was that of Mr. Melville Dewey, which has been adopted in many of our large libraries. It includes statistics, political science, political economy, law, administration, associations and institutions, education, commerce and communication, and customs and costumes. Whenever medical knowledge is necessary to the elucidation of questions coming under either of these divisions, there are to be found problems of medical sociology.

The Academy has been devoting its energies to one class of educational problems, but this has so far advanced toward solution that it does not now require the entire effort of the Academy, and it will be well for it to enter this territory, at present unoccupied by any medical society.

The importance of the study of medical sociology may be seen from a consideration of the importance of some of the questions that ought to be discussed. The "political powerlessness of the medical profession" is acknowledged by all. As physicians usually endeavor to have legislation for the benefit of the community, and not for personal ends, this fact is to be deplored; and if the profession could wield the political power that it ought, much could be done for the common weal. The problem of the prevention of pauperism is one of the most pressing of the age and involves medical ques-

tions. Not the least among them is use and abuse of the free dispensary.

DR. CONNOR thought it wise to extend the same study to medical men as to bacteria, etc. Medical men have a great burden of secrets; they are, however, the silent men of the community. The medical profession thus differs greatly from other professions and is thus at a disadvantage. The relations of medical men to each other are peculiar and beyond the comprehension of the outside world. The medical man, indeed, is one of the pilots of life. In the lines of education these problems of medical sociology have a place. The study of the Constitution and the ideal arrangement would unite the profession into a band of brothers, working for the world, and based, so far as association goes, on scientific work.

In discussing the paper of Dr. Gould, DR. BAYARD HOLMES made a plea for a closer study of our requirements for endowment. How much will it require to run, in a first-class educational manner, a medical school with a four-year course and four hundred students, or forty students each with a good preliminary education? In one of the large cities it will cost fifteen thousand dollars a year, not including a dollar of salary to teachers. If in computing the salaries for instructors the standard of four recitation-hours daily in each of four years be taken, there would be sixteen recitation-hours that must be provided for. As about two-thirds of this work is either laboratory or clinical work, at least ten additional hours must be allowed, *i. e.*, twenty-six hours of the teachers' time will be consumed. An average day's work for a college teacher is two hours. It would then require at least thirteen teachers devoting full time to teaching. The salary of these men at $3000 a year would be $39,000, which, if added to the running expenses, makes a total expense of $54,000 a year for the ideal medical school conducted for education only. It may be said that clinical teachers should not be paid, but it is desirable that every teacher should be paid moderately.

There is now a great endowment going to waste or being perverted. The public pays for the care of the poor in public hospitals, and yet the cases are not used for educational purposes. Every free hospital should be a training-school for medical men and medical students. The public deserves this, and the patients would receive better care.

The noble endowment that has been given hospitals in the name of charity is not always well directed. Thus, the extravagantly constructed Johns Hopkins Hospital costs more to keep in repair than would suffice to run a medical school. These great hospitals pauperize the people, pervert the legitimate rewards of the medical profession, render it so niggardly paid that the educated and refined cannot find in it a life-work.

The universities should be called on to do as well by medicine as they do by other schools. This is not done now.

The following officers were elected for the coming year: President, Dr. George M. Gould, of Philadelphia; First Vice-President, Dr. C. C. Bombaugh, of Baltimore; Second Vice-President, Dr. J. McF. Gaston, of Atlanta, Ga.; Third Vice-President, Dr. S. W. French, of Milwaukee, Wis.; Fourth Vice-President, Dr. C. W. Foster, of Woodyard, Me.; Secretary and Treasurer, Dr. Charles McIntire, of Easton, Pa.

NEWS ITEMS.

Fatal Quackery.—A terrible story comes from a Hungarian city. A family of eight persons were suffering from scabies, and a wise woman was consulted, who sold them a strong mercurial ointment, with which the whole body was to be freely rubbed. The ointment, made of putrid fat, set up septicemia in a few days, and when a medical man was called in two children were already dead and a third lay dying. It was further stated that the remaining members of the family would also probably succumb.—*Medical Press and Circular.*

Pasteur Institute in the Punjab.—It is proposed to establish a Pasteur Institute in the Punjab Himalayas for the treatment of hydrophobia and for scientific research. To make available the benefits of the Institute to the whole of India, patients are, when necessary, to be conveyed free of charge from any part of India to the Institute.

Paul Guttmann, Sanitary Councillor and Director of the Hospital Moabit, died at Berlin on May 24th, of pneumonia complicating influenza, at the age of fifty-nine years.

James Moleschott, the distinguished physiologist, comparative anatomist, and anthropologist, died on May 20th, at Rome, of erysipelas, aged seventy years.

Mr. Marcus Beck, Professor of Surgery at University College, London, died May 21st, of diabetes.

BOOKS AND PAMPHLETS RECEIVED.

How to Operate for Hemorrhoids. By Charles B. Kelsey, M.D. Reprinted from the Therapeutic Gazette, 1893.

Free Incision of Abscess of Ostitis of Hip, and Closure without Drainage. By H. Augustus Wilson, M.D. Reprinted from the Transactions of the Philadelphia County Medical Society, 1893.

Practical Details in the Preparation of Plaster-of-Paris Bandages. By H. Augustus Wilson, M.D. Reprinted from the Philadelphia Polyclinic, 1893.

A Clinical Lecture on the Prevention of Idiopathic Rotary Lateral Curvature of the Spine. By H. Augustus Wilson, M.D. Reprinted from Annals of Gynecology and Pediatry, 1893.

The Influenza Bacillus. By J. A. Comstock, M.D. Reprinted from the Southern California Practitioner, 1893.

The Creation of God. By Jacob Hartmann, M.D. New York: The Truth Seeker Company, 1893.

Metatarsalgia (Morton's Painful Affection of the Foot), with an Account of Six Cases Cured by Operation. By Thomas S. K. Morton, M.D. Reprinted from the Transactions of the Philadelphia Academy of Surgery, 1893.

The Internal Treatment of Lupus Erythematosus with Phosphorus. By L. Duncan Bulkley, A.M., M.D. Reprinted from the American Journal of the Medical Sciences, 1893.

Clinical Study and Analysis of 1000 Cases of Psoriasis. By L. Duncan Bulkley, A.M., M.D. Reprinted from the Maryland Medical Journal, 1891.

Third Biennial Report on Vital Statistics of the State of Minnesota for the Years 1890–91. Minneapolis: Harrison & Smith, Printers, 1893.

Certain Problems in Abdominal Surgery, Based on One Hundred Celiotomies done at the Kensington Hospital for Women. By Charles P. Noble, M.D. Reprinted from the Transactions of the Philadelphia County Medical Society, 1893.

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MEDICAL NEWS.

A WEEKLY MEDICAL JOURNAL.

Vol. LXII. No. 25. Whole No. 1067. SATURDAY, JUNE 24, 1893. Per Annum, $4.00. Per Copy, 10 Cents.

Contents.

Entered at the Post Office at Philadelphia as Second-Class Matter.

In Re O. C. PEROXIDE OF HYDROGEN.

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REPORTS ON VINOLIA.

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M. D. reports:—"I have used Vinolia *always with good results*, especially in cases of eczema and acne."

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M. D. reports:—"I have made extensive use of Vinolia, *and find it more valuable every day.* My latest use of it has been to allay the irritation of a part which had been painted with tincture of iodine, which it did most effectually. In a case of inflamed acne rosacea, I have also proved it a great comfort. I fancy that its range of usefulness will increase as it becomes better known."

ACNE AND ECZEMA.

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Medical Letters may be addressed to:

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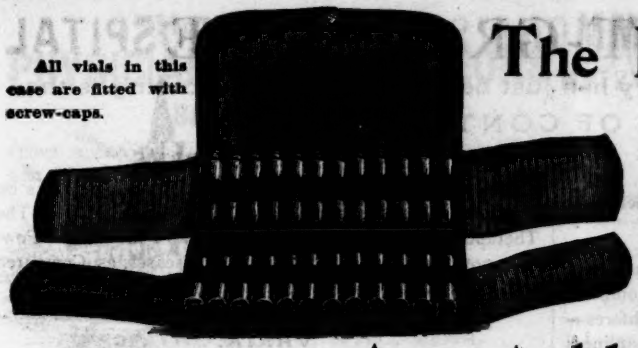

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